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ABSTRACT

This is a non-technical report based on the final report of the first year evaluation of the Head Start/Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Collaborative Effort, a demonstration program initiated by the Office of Child Development (OCD)/HEW in 1974. The report presents and analyzes data collected during the first year of the program, sets forth key policy considerations based on study findings, and seeks to provide direction for policy and program planning. Section I presents a summary of the major findings by specific issue area. Section II presents background information on the EPSDT and Head Start Programs and the collaborative effort. Section III describes the study methodology employed in the evaluation. Section IV discusses the organization and operation of the Head Start/EPSDT Collaborative Effort. Section V examines Medicaid certification results and reviews prior health care status of participating children. Section VI analyzes the provision of health services during the first year of the collaborative effort. Section VII offers an analysis of the state EPSDT plans and compares these to the Head Start Program Performance Standards. Section VIII cites the technical assistance needs of the projects. Section IX provides cost utilization factors related to the collaborative effort. This report is to be circulated to Head Start projects and interested agencies to provide them with background information for administering and improving health services to low-income preschool children. (Author/MS)

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HEAD START/EPSDT COLLABORATION EVALUATION

NON-TECHNICAL REPORT

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INTRODUCTION

This is a non-technical report based upon the final report on the first year evaluation of the Head Start/Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Collaborative Effort, a demonstration program that was initiated by the Office of Child Development (OCD)/HEW in 1974. In initiating the program, OCD/HEW set forth the following objectives:

- to assess the benefits in terms of increased services for both Head Start and non-Head Start children and to establish the dollar value of these services
- to determine any barriers which prevent the Head Start program from making maximum use of Medicaid/EPSDT to pay for required health services provided to Medicaid eligible children in local programs
- to analyze long-term program and policy issues concerning Head Start services to young children as a basis for improving those services in Head Start/Medicaid EPSDT.

This report has been prepared by Boone, Young & Associates, a private consulting firm under contract with OCD/HEW to evaluate the Head Start/EPSDT Collaborative Effort. It presents and analyzes data collected during the first year of the program, sets forth key policy considerations based on study findings, and seeks to provide direction for policy and program planning.

This non-technical report will be circulated to Head Start projects and interested agencies to provide them with background information to aid in administering and improving health services to low-income, preschool children. The Interim Report--providing a detailed analysis of the programs prior to the initiation of the collaborative effort, including in-depth tabular compilations--and the Final Report--discussing the history of Head Start and EPSDT, and updating the data of the Interim Report--are available through OCD.

Boone, Young & Associates wishes to extend its gratitude to the OCD staff for its cooperation in implementing the evaluation study design. We also wish to expressly thank the staff of the funded projects, without whose cooperation this study would not have progressed.

ORGANIZATION OF THE REPORT

Section I presents a summary of the major findings by specific issue area.

Section II presents background information on the EPSDT and Head Start Programs and the collaborative effort.

Section III describes the study methodology employed in the evaluation.

Section IV discusses the organization and operation of the Head Start/EPSDT Collaborative Effort.

Section V examines Medicaid certification results and reviews prior health care status of participating children.

Section VI analyzes the provision of health services during the first year of the collaborative effort.

Section VII offers an analysis of the state EPSDT plans and compares these to the Head Start Program Performance Standards.

Section VIII cites the technical assistance needs of the projects.

Section IX provides cost utilization factors related to the collaborative effort.

Appendix A : Profile of IMPD Projects

Appendix B : Summary of Forms

I: SUMMARY OF MAJOR FINDINGS, CRUCIAL PROBLEMS AND KEY POLICY CONSIDERATIONS

This section summarizes the major findings of the first year evaluation of the Head Start/EPSDT Collaborative Effort and presents the crucial problems and key policy considerations for the following issue areas:

1. Medicaid certification for Head Start and non-Head Start children
2. Previous health care status of Head Start and non-Head Start children
3. Receipt of health services during the first year
4. EPSDT reimbursable services provided/obtained during the first year
5. Supportive services provided to non-Head Start children
6. Comparison of Head Start Program Performance Standards and State EPSDT Plans
7. Analysis of State EPSDT plans and providers' performance
8. Cost utilization factors pertaining to service delivery
9. Technical assistance needs of the projects and staff characteristics.

In assessing the first year evaluation, several conclusions may be drawn from the first year findings. First of all, the Head Start projects were reasonably successful in accomplishing the objectives of the collaborative effort. Many Head Start children were screened during the first year, even though they were not always Medicaid certified. Morever, in the projects selected for in-depth study, there was much concentrated effort to assure the completion of services.

Secondly, and on the positive side, Head Start programs initiated relationships with many public welfare, health and social service agencies, and private sector providers, and reinforced existing contact with such groups. In some target states, Head Start programs stimulated greater interest in EPSDT within local communities and among concerned state agencies.

The major objective of the collaborative effort was to increase health services to children ages 0-6 through effective utilization of the EPSDT program by Head Start. In order to accomplish this task, OCD awarded supplemental grants to 200 Head Start projects whose main responsibility would be to devise specific program strategies to carry out OCD's objectives. These grants were awarded on the basis of applications submitted by the programs which described the potential and actual Medicaid/EPSDT population within Head Start and the surrounding community, and their plans for mounting an effective collaborative effort. The projects selected constituted the national sample for the evaluation study. Thirty of these were selected for in-depth analysis.

The projects represented a wide spectrum of the national Head Start program but showed a strong rural bias despite the high incidence of Head Start programs in low-income urban areas generally. Many ethnic, cultural and linguistic groups, including blacks, Chicanos, American Indians, poor whites were part of the national sample. Also, specific Head Start projects--the Indian and migrant workers' demonstration projects (IMPD)--were included. The numbers of children receiving Head Start services in individual projects ranged from 60 to 2,500. In choosing the selected sample of thirty projects, efforts were made to insure that the selected group approximated the characteristics of the national sample with corrections for rural bias.

OCD established several priorities for these demonstration projects during the first year. The most important priority was to provide EPSDT services to as many Medicaid eligible Head Start children as possible and enroll in Medicaid the maximum numbers of Head Start children not yet certified by the medical assistance program. As a second priority, Head Start projects were to conduct community-wide recruiting for non-Head Start Medicaid eligible children. For this population, also, the projects were to assure certification of the Medicaid eligible children.

During the first year of the collaborative effort, the Head Start projects reached 129,234 Head Start and non-Head Start children. (This figure was calculated by extrapolating the total number of children reported screened, 95,997, by 147 projects to the universe of 198 programs that had received supplemental grants.) For children diagnosed or treated, the extrapolated number for the 198 programs is 26,933 children.

For the Head Start projects, the first year of operation for the collaborative effort was primarily a developmental period, with many trial and error learning experiences. During this period, the demonstration projects had to phase in the collaborative effort as well as familiarize themselves with the various forms being used in the evaluation study.

Many did not realize the potential for services to non-Head Start children through utilization of community resources. In some cases, too, the projects were stymied by the reaction of public agencies or the difficulty of intermeshing with the state EPSDT system. Reviewing the level of participation in terms of number of children against the generally limited technical support received by the demonstration projects, the level of activity--greatly varied among individual projects--is understandable and, in some instances, commendable.

The major findings and policy considerations, as well as crucial problems related to these, are detailed below by issue area.

Issue Area 1: The extent to which the projects achieved Medicaid certification for Head Start and non-Head Start children.

FINDINGS:

- Head Start projects were reasonably successful in reaching and reviewing children for Medicaid eligibility, but the majority of children--both Head Start and non-Head Start--who were reported as Medicaid certified began the EPSDT Collaborative Effort with that status (60%) (17,989 out of 25,737).

  The projects were more successful in reaching and reviewing non-Head Start children for Medicaid eligibility, but the majority of the non-Head Start youngsters were the siblings of Head Start enrollees who were already certified, rather than siblings in those Head Start families believed eligible but not yet certified.

- The projects were highly successful in obtaining Medicaid certification for non-Head Start children who had not been certified prior to entry into the collaboration (83%, or 10,178 out of 13,277). They were less successful with the Head Start population (30%, or 14,684 out of 38,912), reflecting possible discrepancies between the eligibility standards for Medicaid and Head Start.

- The parent involvement component was generally useful in providing for outreach, screening, and establishing Medicaid eligibility, particularly for the siblings of non-Head Start children.

- There were wide variations among regions and among selected projects in the numbers of children--Head Start and non-Head Start--for whom Medicaid certification was achieved.

PROBLEMS:

- Limited staff resources and the lack of clarity as to the degree of involvement by Head Start staff in the recruitment of non-Head Start, non-sibling children were apparently important adverse factors in reaching these children.
- The differences in eligibility standards for Medicaid and Head Start services may have affected the number of children who were found to be Medicaid eligible by the projects. States with appreciably low Medicaid standards may have been unable to accept low-income children recruited by the Head Start projects for the collaborative effort.
- Many children apparently experienced considerable fluctuation in their Medicaid status over the year, with possible detrimental results for health care continuity.

POLICY CONSIDERATIONS:

- Systematic planning, including reliable estimates of the number of children to be served and information on the type of supportive services available, would be likely to enhance certification efforts through improved deployment of staff resources.
- Local Head Start programs could use standardized procedures for assessing Medicaid eligibility by Head Start programs so that the accuracy of Medicaid certification referrals might be increased. Also, review

could be undertaken by OCD of barriers to EPSDT eligibility for Head Start enrollees because of some states' low-income criteria.

- Head Start programs could establish closer working relationships with local EPSDT agencies to speed the determination and certification process of a referral child.
- The number of potentially eligible children brought into EPSDT could be increased were the projects given greater assistance in developing outreach techniques, and were greater stress placed on the demonstrably successful parent involvement component.
- Because the income eligibility differences (in dollars) tend to be minimal between Medicaid and Head Start, OCD may wish to review with SRS the feasibility of providing Medicaid certification to low-income, preschool children on the basis of their enrollment in Head Start.

Issue Area 2: Previous health care status of Head Start and non-Head Start children.

FINDINGS:

- Nearly all of the previously enrolled Head Start children (92%, or 6,792 out of 7,343) had received screening services primarily through Head Start prior to entry into the EPSDT effort, and Medicaid certification or eligibility was not a factor in receipt of these services.
- Few projects reported children--Head Start or non-Head Start--who received mental health, medical, and nutritional services prior to entry into EPSDT.
- Non-Head Start children who had received health services prior to entering EPSDT were primarily Medicaid certified and siblings of Head Start enrollees.

PROBLEMS:

- The availability of various health services in a local area, with some communities apparently having significantly greater resources than others, may have determined the incidence of prior health care to some degree in any particular region.
- The similarity in incidence between Head Start and non-Head Start children who received screening services prior to EPSDT entry may reflect the concentration by some Head Start programs in providing family health services rather than focusing on the needs of the enrolled Head Start child, alone. Apparent emphasis in the projects on supplying dental services for Head Start enrollees may explain the relatively lower rate of dental care for non-Head Start children.

POLICY CONSIDERATIONS:

- Head Start programs might be encouraged to arrange for family health services, thereby ensuring that all family members, including children, are provided comprehensive care. Similarly, the projects could be assisted in defining their responsibility for recruiting participants beyond the immediate Head Start family as part of the Head Start performance standards.
- Limitations in some state plans for Medicaid/EPSDT could be overcome through implementation of national standards for the provision of health services to low-income, pre-school children.
- Greater assistance for Head Start programs in improving utilization of community health resources would result in expanded screening services through augmentation of the programs' own capabilities.
- Additional assistance for Head Start programs would enable them to become more aware of the overall developmental health of pre-school children. Particular stress could be placed on nutritional and mental health development.

Issue Area 3: The extent to which the projects provided/obtained health services for Head Start and non-Head Start children during the year.

FINDINGS:

- There was a fourfold increase in the number of children screened this year compared to last year. The vast majority of children screened (86%, or 82,782 out of 95,997) were Head Start enrollees. Most of these screenings, however, were incomplete at the time of reporting. Although there was an increase in the number of non-Head Start children screened, it was not as great.
- Although relatively large numbers of children were screened, only one out of five were diagnosed or treated. For those treated, acute or chronic care was most often provided for both Head Start and non-Head Start children; and each child received 2.6 units of treatment.

PROBLEMS:

- The availability of particular health services in a given area again influenced the incidence of their receipt this year, particularly psychological and nutritional services.
- The lack of information about the nature or quality of screening and other health services provided limits the assessment about the impact of these services upon the health status of the children.

- The relatively large number of Head Start children participating who were ineligible for Medicaid or of unknown status means that the Head Start projects most likely had to pay for services rendered from their own program resources, even if the services were available through the state EPSDT plan.

- As in the case of the previous year, dental care was the most prevalent type of health service provided. There was a fourfold increase in the number of children reported this year.

- More than 90% (8,800 out of 9,623) of the Head Start and non-Head Start children who were reported having mental health services received psychological testing (type of test administered unknown) but few were counseled or referred for further services.

- Nutritional services were again the least frequently provided. A greater number of children receiving these services were referred for additional assessment compared to other health services.

- Medicaid certification appeared to be unrelated to the receipt of health services, as the proportion of Head Start and non-Head Start Medicaid certified children was almost equal to those who were ineligible or of unknown status.

POLICY CONSIDERATIONS:

- The screening package mandated for Head Start children might be defined in greater detail (test specification, for instance) to assure measures of comparability among Head Start programs, as has been reflected on the 1975 revision of the Head Start performance standards.

Further studies regarding the quality of health services received could provide the basis for revising standards for health care.

- Additional program resources to Head Start projects would greatly enhance their capability in providing services to families of Head Start children. The parent involvement component could be particularly useful toward this end.

Issue Area 4: Extent to which the projects were able to provide/obtain direct EPSDT reimbursable services for eligible children.

FINDINGS:

- Only two Head Start projects obtained direct reimbursement by Medicaid EPSDT, either as vendor or through purchase of health service agreements.

PROBLEMS:

- There was only one contract reported between a public agency and a Head Start project. Relationships were generally quite informal, with minimal assistance or support provided by public agencies to Head Start projects. In fact, many projects reported resistance by public agencies, particularly at the local level, regarding Head Start roles in EPSDT delivery.
- Many projects relied on previous patterns of health service arrangements in the case of Head Start children, possibly minimizing the use of Medicaid.

POLICY CONSIDERATIONS:

- The EPSDT coordinator could be trained to have close familiarity with Head Start program objectives and health-related matters so that there can be full integration of the EPSDT effort into the overall Head Start program. The position will benefit in this regard, should it be made full-time and be placed under the supervision of the health services coordinator.
- OCD might encourage more reimbursement relationships through ensuring that the projects have available full information on the availability of EPSDT services in their areas.

Issue Area 5: Extent to which supportive services were provided to non-Head Start children.

FINDINGS:

- There were limitations on the level and adequacy of supportive services provided to non-Head Start children. The Head Start projects were the major providers of these services to non-Head Start children, suggesting a general understanding of intent of the EPSDT Collaborative Effort. The parent involvement component was the most effective tool in outreach to non-Head Start children.

PROBLEMS:

- Previous approaches to providing supportive services in the Head Start programs were generally maintained during the collaborative effort, limiting the provision of supportive services to non-Head Start population.
- Public agencies tended to focus their supportive services on follow-up rather than outreach, again limiting the number of non-Head Start children served. The voluntary sector proved to be of minimal help to the projects in delivering supportive services.
- The non-Head Start child was less likely to receive follow-up services, particularly verification, possibly related again to emphasis by the projects on previous patterns of supportive services delivery.
- Recordkeeping for non-Head Start children was considerably weaker than for Head Start children, possibly the result of a lack of resources in the projects.

POLICY CONSIDERATIONS:

- Better coordination between Head Start projects and public agencies would provide more consistent and expanded delivery of supportive services to non-Head Start children. The projects might also seek reimbursement for these services provided they are part of the state EPSDT plan.
- Head Start projects might be encouraged to utilize more fully whatever resources are available in the voluntary sector for delivery of supportive services, particularly in the areas of outreach.
- Head Start programs might be encouraged to use the parent involvement component to the fullest extent to ensure that all siblings of Head Start enrollees become participants in the EPSDT effort, thereby also expanding provision of supportive services. Likewise, door-to-door contact could be used more extensively as an outreach technique
- Requirement of recordkeeping on the provision of services to non-Head Start children by the projects would both maximize supportive service delivery and improve procedural quality in all aspects of the collaborative effort.

Issue Area 6: Comparison of Head Start Program Performance Standards and state EPSDT plans.

FINDINGS:

- The state plans' description of supportive services is particularly limited, and may not provide the same degree of delivery as Head Start potentially could.
- There is no uniformity regarding the types and quality of services provided among the various states.

PROBLEMS:

- With the exception of California, none of the states provide a mechanism for consumer participation in their EPSDT plans.
- Although most states cite the importance in their plans of coordination with existing health resources, none specify procedures for ensuring that linkage does occur.
- Lack of specificity and uniformity in regard to types and levels of service provided, complicates the collaborative process for an agency such as Head Start, and necessitates a state by state analysis of the health benefit package.
- In those states which provide reimbursement for the entire screening package, Head Start, even if it achieves vendor status, may not be able to receive reimbursement unless it delivers the entire package of screening services.

POLICY CONSIDERATIONS:

- Development of uniform national standards for EPSDT plans, by types and levels of services, and provision for reimbursement might expedite and facilitate the relationship between Head Start programs and EPSDT.

- Consideration might be given to developing reimbursement procedures in state plans which permit payment for provision of specific services rather than an entire package, since a provider might be encouraged through this arrangement to perform procedures which might otherwise have been neglected.

Issue Area 7: Analysis of State EPSDT plans and providers' performance.

FINDINGS:

- State Medicaid/EPSDT plans were characterized by their complexity, with disparate delegation of responsibilites to different public and private agencies at both the state and local levels.
- There was overall failure by the Head Start programs to be integrated into the delivery of Medicaid/EPSDT services at the state or local levels by achieving vendor status.
- The collaborative effort had minimal impact on the institutional arrangements of a state Medicaid/EPSDT plan or program.

PROBLEMS

- The format of many state plans is complex, and often the phrasing is ambiguous or obscure.
- Variations among state plans concerning their reimbursement policies can and do lead to alienation and frustration among vendors who apply for reimbursement for services not sanctioned by the plans.
- Providers often fail to offer areas of screening when these services are not explicitly permitted for reimbursement under the state plan.
- Restrictions in the plans on the awarding of vendor status to community agencies limits the availability of supportive service and the potential for Head Start and similar groups to become service vendors.

POLICY CONSIDERATIONS

- Clear and precise information on the operational and procedural aspects of state EPSDT plans might be provided to Head Start programs, as well as to other agencies and consumers, in order to increase the efficient use of these resources and services.
- More effective integration of Head Start and EPSDT services might be accomplished through review by SRS of Head Start's provision of the specific services rendered. Health liaison specialists may have an important role to play in this regard, through their active intercession between Head Start programs and local EPSDT/Medicaid agencies to promote closer and more efficient working relationships.

(For considerations on vendor and provider problems, see Issue Area 5, Policy Considerations.)

Issue Area 8: Cost utilization factors pertaining to service delivery.

FINDINGS:

- Although expenditures for Head Start/EPSDT varied from project to project, the average cost per child was assessed at $45.00.
- About 75% of the total EPSDT expenditure for all regions and IMPD programs originated from the Head Start/EPSDT supplemental grant. Contributions from other sources were minimal.
- Some programs extended beyond the supplemental grant to support the collaborative effort, suggesting that the grant, alone, was not sufficient to sustain the implementation of EPSDT/Head Start.
- Overall, 48% of all dollars expended for the EPSDT program were for direct health services, with 27% and 25% attributable to supportive costs and administrative costs, respectively.
- Most of the time (55%), payment for provision of EPSDT health services included Head Start funds, leading to the conclusion that Head Start provided the major financial support to the collaborative effort.

PROBLEMS:

- Lack of providers, failure to reimburse for certain services in accordance with a state EPSDT plan, and infrequent use of reimbursement for mental health and nutritional services may be contributing factors to the low percentage (6%) of Medicaid/EPSDT services.
- Some lack of discretion regarding administrative costs may have had an adverse impact on the level of services provided.

POLICY CONSIDERATIONS:

- Review could be undertaken by the projects to determine how monies directed toward meeting the objectives of the collaborative effort could be maximized, and how monies directed to lower priority areas within the effort could be minimized.

- Projects might begin to develop a system containing provisions for identifying reimbursement areas and requirements. Such a system may also improve managerial procedures for the projects and may clarify objectives and methods of attaining them.

- Because of the unreliability of cost/revenue data, more emphasis might be placed on the retrieval of this information during the second year evaluation.

- For the supplemental grant, monies might be more effectively distributed according to a formula that takes into account program size and other variables.

- Designation by the local/state Medicaid agency of the Head Start program as a provider of health services would ease reliance on the supplemental grant and would also faciliate service delivery (supportive and health related) to the target population.

- Where such designation is not possible, programs may be encouraged to reach agreements with local health providers that are recipients of third party payments, to share in any monies received as a result of services delivered to children referred by the projects.

- A sliding fee scale system might be implemented, selectively, to facilitate payment for direct services (to non-Medicaid eligible families only).

Issue Area 9: Technical assistance needs of the projects and staff characteristics.

Technical Assistance Needs

FINDINGS:

- Head Start projects had particular technical assistance needs in the areas of outreach and follow-up. For the former, there was a need to plan and develop a strategy with the state and local EPSDT agencies. For the latter, there was a need to plan and develop systems which effectively met this objective.
- To the degree that any source was helpful in providing technical aid, the health liaison specialist was most frequently cited. Overall, however, the projects reported minimal technical assistance provided.
- The most frequent type of technical assistance provided was in the form of workshop and information provision.

PROBLEMS:

- State Medicaid/EPSDT agencies were usually not a source of technical assistance to the projects as had been anticipated.
- The agent with the responsibility for negotiation with state/local Medicaid agencies for vendor recognition was not pinpointed by OCD or regional offices; nor was there any assistance provided in arranging fiscal affairs or administrative procedures.

POLICY CONSIDERATIONS:

- Administration and planning, as well as development of coordination and linkages between the projects and the Medicaid agencies, are potentially fruitful areas for concentration of technical assistance during the second year effort.
- The role of the health liaison specialist might be more clearly defined in regard to its ongoing technical assistance function and as a link between the projects and the Medicaid agencies.

Staff Characteristics

FINDINGS:

- A majority of the EPSDT coordinators were full-time personnel with some college background and several years of previous experience in Head Start.
- The organization of EPSDT, as an additional responsibility for the Head Start health service components, often placed severe strain on existing staff.

PROBLEMS:

- Training of health and other staff for the EPSDT effort was generally limited, and consisted primarily of OCD workshops.

POLICY CONSIDERATIONS:

- Training of the Head Start staff, particularly those members who have direct responsibility for the operation of the collaborative effort, is crucial.
- Head Start programs could be encouraged to recruit and hire persons with professional background in the EPSDT/Medicaid program, who would then be responsible for coordinating Head Start/EPSDT services. This position might best be utilized were it made full-time and placed under the supervision of the health services coordinator.

II. BACKGROUND OF EPSDT PROGRAM AND THE COLLABORATIVE EFFORT

A. LEGISLATIVE HISTORY OF EPSDT

The 1967 amendments to the Medicaid provisions, Title XIX, of the Social Security Act set up a national program of preventive health services for low-income children ages 0-21 through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. These amendments were signed into law on January 2, 1968 to become effective July 1, 1969 and they represented several years' efforts by HEW officials to expand health and medical care for poor children by establishing federal standards for coordination and provision of services. Because children on public assistance was a major group to receive these services, this new and extensive child health program was integrated into the public welfare system which also carries responsibility for other income maintenance and medical assistance programs, including Medicaid.

Until the passage of the 1967 legislation, federal money for child health services had been provided primarily through Title V of the Social Security Act which had authorized screening services since 1935 through Maternity and Child Health (supervision of preventive services and well-baby clinics) and Crippled Children Services (diagnosis and treatment). In the early 1960's, there was an expansion of health services for children at the federal level. As an effort to bring about coordination of these various resulting health services, federal provisions for EPSDT called for the Title XIX (Medicaid) agency in each state to enter into agreements with the Title V agency (Maternal and Child Health, usually the Health Department) so that such agencies might be providers of services to be reimbursed through Title XIX. The eighteen-month delay before regulations were written and distributed by HEW for implementation of the EPSDT program has been attributed to the resistance by the states to providing the extensive screening and subsequent diagnosis and treatment called for because of their cost.

Regulations currently in effect were issued by the Social and Rehabilitation Services (SRS), the administering unit in HEW for EPSDT, in November 1971 to be effective February 1972. These extended the date for full implementation of the EPSDT program and allowed the states to initiate these services by apportioning the children to be served on the basis of age. The age group to be served first was to include children ages 0-6, with services gradually expanded to include all youth up to age 21 by July 1, 1973.

Because of increasing public concern about the delay in implementing EPSDT, Congress passed further amendments calling for penalties against any state (1% of the federal share of AFDC for each quarter of non-compliance) which did not provide for full implementation of the program by the specified time period.

B. DESCRIPTION OF MEDICAID/EPSDT

Because EPSDT is an integral part of Medicaid, the rules and regulations that pertain to the administration of that medical assistance program are applicable to EPSDT as well. Medicaid can be described as a federal-state financed, state administered program with the federal contribution varying from 50% to 83% of cost, depending upon the provisions of an individual state plan. Medicaid (and EPSDT) is usually administered on the state level by the public welfare department under the single state agency rule of the Social Security provisions.

The federal guidelines for the program are broad and general and only certain basic services are mandated. Thus, states have wide latitude in defining the scope and nature of the services to be provided within their area. Rather than being viewed as one uniform national program, Medicaid and EPSDT can best be described as programs which are administered on the basis of 49 separate state plans which resemble each other only in their basic minimum requirements. (The state of Arizona does not participate in the Medicaid program.)

Individual state plans provide varying definitions for Medicaid and EPSDT services in several areas.

1. Eligibility level: All states must serve the categorically needy as defined by federal regulations but the state has the option of setting definitions for serving the medically indigent, i.e., those low-income families who are not public assistance recipients.

2. Provider status: The state can establish criteria for awarding vendor status to providers of medical services and thus restrict the category of persons or groups to be reimbursed for services rendered to the medically needy. In some states, only licensed private physicians are reimbursed; while in others, services rendered by neighborhood clinics or nurse clinicians are reimbursable also.*

3. Benefit structure: Beyond the minimum services required by regulation, the states have the option of determining additional benefits, if any, to be offered to Medicaid recipients. These benefits can be limited by utilization controls. For example, California Medicaid recipients are permitted two physician visits per month (except for EPSDT services).

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*The Health Liaison Specialist from the American Academy of Pediatrics could be helpful as a potential source in advocating for particular types of medical providers to be selected.

4. Reimbursement rates: States determine the rate at which providers are reimbursed for services rendered. Reimbursement methods range from payment for "reasonable cost" to a flat rate for specific services which bears little relationship to the cost of providing the same service in the private sector.

5. Billing and collection procedures: Billing and collection procedures also vary from state to state and may affect the submission of bills and the frequency and rapidity of payment to providers. For instance, in many states, there is a lag of several months between the time a service is rendered and payment is received by the provider. This factor together with low reimbursement rates tend to reduce the number of providers participating in the Medicaid program.

Impact Upon the Delivery of EPSDT

The problems that have been identified in the administration of Medicaid, both in the provision and definition of services as well as the overall management, have immediate impact upon the scope and nature of the EPSDT program and create barriers for its effective implementation.

Federal regulations for EPSDT designate the state Medicaid agency (public welfare unit) as responsible for providing or obtaining health services for EPSDT-eligible children. This responsibility includes such supportive services as outreach (locating and informing families with eligible children about the program) and recruitment of both consumers and providers of EPSDT services. In most instances, the emphasis in program implementation has primarily been upon screening, reflecting the major new service mandated through the authorization of the EPSDT program.

Because the availability of providers and community health resources is uneven around the U.S., the development of a linkage system whereby eligible children can be routinely referred for a whole range of EPSDT services has created a major problem for planning and administration. Moreover, state welfare agencies do not perceive that they have a primary role in the delivery of health services, since most find their time consumed in the administration of public assistance and social services.

Several questions can be posed regarding the viability of broad screening programs within the context of comprehensive health care. Health professionals differ among themselves regarding the type of preventive services and screening techniques in relationship to diagnosis and treatment that should be universally available. Moreover, the frequency with which such services should be provided is open to professional judgment. For instance, Dr. Frederick North, a pediatrician, pointed out that there is a 30% loss between referral and appointments kept when screening is rendered separately from the other medical services. Others believe that screening is a convenient way of sorting out individuals who have some likelihood of pathology in a given area.

Therefore, the problems of implementing the EPSDT at the state and local levels may reflect the lack of consensus-public and professional--regarding the construction of a health care system as well as certain inadequacies in that system as now operated throughout the U.S. The General Accounting Office, in its Janaury 1975 report on EPSDT*, cited several factors impeding the program: inadequate outreach techniques, lack of utilization of allied health professionals, inadequate procedures for period updating of screenings and inadequate follow-up mechanisms, again inflecting the lack of comprehensive approaches to health care as well as a failure to fully adhere to federal standards.

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*Improvements Needed to Speed Implementation of Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program. Comptroller General of the United States, DHEW, Social and Rehabilitation Services, Washington, D.C., Januray 9, 1975.

Even if EPSDT were fully implemented these services would only reach about one half of the nation's 25 million children in low-income families. (There are 13 million Medicaid eligible children nationally, according to the House Subcommittee report.) Most of the children eligible for EPSDT are beyond the reach of the health care system because of its emphasis upon crisis or emergency care.* Yet it is these children who have the highest incidence of correctible medical problems.** The basic challenge of EPSDT, therefore, is to trigger changes in health care delivery for children as a first step toward evolving a truly comprehensive health program.

Head Start is a national demonstration program to provide comprehensive developmental services to low-income pre-school children, and in its ten years' existence it has become preeminently identified as an effective model for the delivery of integrated human services. Since its inception, Head Start program goals have stressed an interdisciplinary approach to child development in order to assure that the various services, staff functions, and skills needed to enhance the social functioning of the child and his family might be available. Head Start was originally conceived in 1964 within the context of a community action strategy.* The intent at the time was to demonstrate the efficacy of intervention into the life of the "disadvantaged child" through a host of education, health and nutrition, and social services arrayed with the parent and community as partners in the service delivery process.

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*ABC News Closeup on Children: A Case of Neglect. Transcript of Broadcast over the ABC Television Network, July 17, 1974.

**Ibid.

The Office of Child Development/DHEW, now the administering unit for Head Start, has reinforced the program's priority goal of achieving social competency among low-income, preschool children through the issuance of performance standards. These standards, revised as of July, 1975, set forth the goals and objectives of four components--Education, Social Services, Parent Involvement, and Health--which must be part of each Head Start program.**

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*Head Start was an integral part of the Economic Opportunity Act of 1964. Its most recent enabling legislation is the Head Start, Economic Opportunity and Community Partner Act of 1974.

**A full discussion of the Head Start Program Performance Standards is presented later in this report.

Head Start now provides services to 350,000 children nationally, 80% on an annual basis, through an annual authorization of approximately $400 million.

Head Start has achieved notable success in meeting specific goals to improve the health and nutritional status of its enrollees. The New York Times, in an article dated June 8, 1975 was laudatory in its praise of Head Start efforts to provide standardized health care to preschool children in low-income communities. As of 1973, Head Start has also been viewed as an appropriate community service to recruit and provide services to handicapped children because of its intensive outreach and integrated services approach.

III. GENESIS OF THE COLLABORATION BETWEEN HEAD START AND MEDICAID/EPSDT

In December 1973, the Office of Child Development (OCD) and the Medical Services Administration (MSA)* jointly announced a collaboration between the Head Start and EPSDT programs. The rationale for this move was recognition that:

- the goal and objectives of the health services components of Head Start and Medicaid/EPSDT are mutual, since both focus on prevention, identification and treatment of illness, and linkage of the child and family to an ongoing health system.**

This common frame of reference could serve as a catalyst to generate a wide range of local collaboration and cooperation between the two programs that would help to strengthen Head Start health components and also assist state and local agencies in administering EPSDT programs.

The strategy of the collaborative effort was to utilize local Head Start programs as a mechanism for making EPSDT services available to Medicaid eligible children 0-6 years.

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*The division with the Social and Rehabilitation Service Unit directly responsible for Medicaid and EPSDT.

**Memorandum dated December 12, 1972 from Howard Newman, Commissioner, Medical Service Administration and Saul Rosoff, Acting Director, Office of Child Development to the Social Rehabilitation Service.

The plan called for Head Start to refer potentially eligible children to Medicaid for certification. In turn, Medicaid would supply EPSDT services in accordance with the state Medicaid/EPSDT plan. Any additional health services for Head Start children not covered by the state Medicaid plan but required by the Head Start Performance Standards would be paid for by local Head Start programs. The Head Start projects approved for participation in the collaborative effort would assist the Medicaid/EPSDT agency by providing health-related support services, including case findings, transportation, public information, referral and follow-up services.

The Head Start projects were also assured that eligible children would receive the EPSDT services to which they are entitled. In addition, the collaboration effort called for projects to provide services to non-Head Start children, including siblings of Head Start enrollees.

Technical assistance was to be provided as part of a national contract with the American Academy of Pediatrics (AAP) which would supply health liaison specialists. The specialists were to assist the local Head Start project in making collaborative arrangements with Medicaid agencies. They were to also provide orientation and training sessions for the Head Start health services coordinators and assist them in planning and implementing the demonstration program.

On December 18, 1973, the Office of Child Development issued specific guidelines for the collaboration effort. These included:

- The collaborative program to be established as a demonstration effort for one year, with the possibility of continuing a second year.
- Staff already employed by Head Start programs in local areas to perform the core activities of the demonstration effort.
- Supplemental grants to be made available to hire additional staff or increase working hours of staff already on board.
- The health services coordinators in the Head Start program to be responsible for implementing the collaboration as well as directing and coordinating all health services, such as:
  - informing families about EPSDT services
  - arranging for transportation
  - aiding families in establishing Medicaid eligibility
  - assisting in securing medical appointments
  - maintaining individual health records to assist in tracking the provision of care
  - arranging for follow-up and referral.
- The health services coordinator to serve as liaison to the child and family, the public welfare and health officials and local health providers.
- The Head Start programs selected for the demonstration to provide health-related support services for Head Start and non-Head Start children recruited for participation in the EPSDT Collaborative Effort.

The criteria used by OCD to select grantees for the collaborative effort included: willingness to participate in the collaboration; ability to implement health services for children; the state Medicaid agency support of the collaboration; the project's ability and willingness to enroll and serve all Medicaid eligible Head Start children. For those projects serving non-Head Start Medicaid eligible children, it would be necessary to identify a significant number of children in the target area who were age 0-6. Priority was to be given to programs able to enroll in Medicaid/EPSDT the maximum number of Head Start children who were not presently served by Medicaid. A second, but important, priority consideration was given to the ability to enroll in Medicaid/EPSDT substantial numbers of non-Head Start children who were not covered by Medicaid.

Study Methodology

In May 1974, the Office of Child Development announced its plans to provide for an evaluation of the Head Start/EPSDT Collaborative Effort. The purpose of the evaluation, according to OCD, was to assess the extent to which the collaborative effort had been successful in achieving its goals and objectives by documenting the outcomes of the demonstration program. Boone, Young & Associates, Inc., was awarded the contract for the study in June 1974.

Project Selection

Thirty projects were selected from the 198 demonstration sites funded for the Head Start/EPSDT Collaboration Effort for in-depth examination and analysis. The sites were chosen within designated target states. Examination of the 198 projects revealed few similarities among the projects because of the highly diversified nature of these programs.

The following criteria were agreed upon as the basis for selection of the thirty projects:

- identification of institutional barriers to the implementation of EPSDT
- programmatic aspects of delivery of health care to children
- rural/urban characteristics
- program size
- program sponsorship
- geographic dispersion within the state.

A profile of the projects selected for an in-depth analysis can be found in Appendix A.

Site Visits

One to two-day visits were made to 24 selected projects. The purpose of the site visits was to obtain information concerning particular issues surrounding the implementation of the Head Start/EPSDT Collaborative Effort; for example, start-up activity, provider arrangements, and relationships with local Medicaid agencies.

Data Collection Instruments and Recordkeeping System

A set of data collection forms designed for the study served two purposes: 1) to obtain information necessary to the evaluation; 2) to support local projects' recordkeeping activities, particularly as related to the health component and the collaboration between Head Start and state and local agencies administering EPSDT. The forms are summarized in Appendix B, and copies of the forms are contained in the Interim Report.

Collected data were transferred to disks, permanent intake files were created, incorrect information was sorted out, and a corrected print-out was obtained. Along the line, re-coding was done when necessary, and respondents were contacted to verify questionable or incorrect information. A sample print-out is included in the Interim Report, along with detailed tables.

IV. ORGANIZATION AND OPERATION OF EPSDT

The Head Start/EPSDT Collaborative Effort was designed to show that Head Start could be effective in increasing the number of low-income, pre-school children receiving EPSDT. Those Head Start projects selected to be demonstration programs modified their operations and organization to include administering the collaborative effort. The experiences of the Head Start projects in the collaborative effort yielded detailed information on management, staffing, planning, supportive services, and health service arrangements.

Administration

Most Head Start projects complied with the OCD mandate to appoint a health services coordinator to be responsible for the administration and coordination of the collaborative effort. The Head Start projects did not act with any uniformity in the carrying out of their responsibilities. Some elected to increase the salaries and work schedules of their health service coordinators with funds from supplemental grants, while others used their monies to appoint new staff, perhaps hiring a special EPSDT coordinator. The majority of the coordinators completed high school, and many were nurses or college graduates.

The OCD guidelines delineate such responsibilities of the coordinators as:

- informing families about EPSDT services
- arranging for transportation
- aiding families in establishing Medicaid eligibility
- assisting in securing medical appointments
- maintaining individual health records to assist in tracking the provision of care
- arranging for follow-up and referral
- training of staff members.

Before tackling the problems of day to day operation, the coordinator must sufficiently acquaint Head Start staff, public service agencies, community health care personnel, and families with the collaborative effort so that the administration can proceed smoothly. Clearly, the effectiveness of the collaborative effort depends significantly on the competence and background of the coordinator. During on-site visits, individual projects stated the need for qualified coordinators, and the successful provision of services to children bears them out: 88% of children served were in projects with coordinators who had prior Head Start experience; 77% of children served were in projects with coordinators who had prior health care experience; and 70% of children served were in projects which had coordinators working full rather than part time. On a negative, but equally illuminating note, one project lost its coordinator and did not secure a replacement for two months. During that interim period, the collaborative effort drew to a virtual halt.

In light of the above considerations, certain policy considerations become evident:

- Proper training of Head Start staff is vital to the success of the collaborative effort.
- Head Start personnel should combine EPSDT activities with regular duties.
- Coordinators should have health related backgrounds and specific knowledge of Head Start and EPSDT.
- Coordinators should work actively and full-time and should include the orientation and training of staff members and outsiders in their activities.

Before the coordinator can administer effectively, he must be fully familiar with EPSDT. Unfortunately, the first year coordinators were largely unaware of such fundamentals as the eligibility requirements, procedures for Medicaid certification, and services available through state EPSDT. Whatever information was available to the coordinators was most easily obtained from the state agencies; however, these agencies did not provide the ongoing support and material to sufficiently help the collaborative effort. A second potential source of information was the health liaison specialist. However, many of the projects indicated that the specialist was not available, and that absence of a specialist was detrimental in that vital technical assistance could not be obtained. Until they receive adequate information from governmental agencies, Head Start projects will continue to be intuitive and general in their adaptation of the collaborative effort, often relying on their own resources and past health practices.

Although the demonstration projects submitted work plans, they did not necessarily keep to the specifics they had proposed. The Head Start projects often encountered difficulties such as:

- the amount of supplemental grants did not meet initial requests
- the responsibility of the projects to non-Head Start children was not clearly delineated
- estimates of time and effort that would be involved were unrealistic
- the OCD administrative requirements were often overwhelming.

Within such a framework, realistic planning for implementing the program was virtually impossible. Because a result of the situation was a proliferation of resource allocation problems within the demonstration projects, Head Start projects might be given more technical support in developing their existing capabilities. Moreover, OCD might wish to initiate a systematic plan including clarification of objectives and strategies for planning.

Like any new undertaking, the Head Start/EPSDT Collaborative Effort staff had to undergo a period of adjustment and of consideration of new modes of activity. Among the difficulties faced by Head Start staff in implementing new arrangements for health services were the resistance of general practitioners to overloading of their schedules and the administrative burdens of detailed screening, problems with monetary reimbursement, and inequitable distribution of health care services. Thus, in arranging for the provision of health services, Head Start projects tended to rely on proven resources. This understandable tendency limited the expansion of services so that, for example, while the projects provided significant nutritional services and screening for their own children, they did not provide as fully for the non-Head Start children.

Supportive Services

Although the collaborative effort suffered because of insufficient government support and confusion within the individual projects, there were positive results in the provision of supportive services to non-Head Start children. Often, Head Start was the sole provider of such services as tracking, verification, and recordkeeping. Public agencies, with regard to non-Head Start children, concentrated on follow-up of children already in the program rather than on recruitment of new participants. Voluntary agencies contributed only negligibly to the effort, often because of their lack of resources. That volunteers could be incorporated into the effort was demonstrated by one or two projects who solicited them; one project, for example, utilized the local university students and another used VISTA workers.

Some Head Start projects did constructively interpret the intention of the collaborative effort with regard to non-Head Start children, but in the great majority of cases, *the overall scope of supportive services for these children could be broadened, toward which end Head Start staff can develop productive working relationships with both public and voluntary agencies*. The local welfare office, for example, might work closely with Head Start to avoid duplication of effort, to expedite certification, and to facilitate the deployment of supportive services. Moreover, Head Start might tap the voluntary agencies for assistance in such service areas as volunteer babysitting.

Outreach

Essential to the success of the collaborative effort is the enrollment of non-Head Start children in EPSDT, and the outreach efforts in this regard were moderately successful. Two of the demonstration projects did not reach any non-Head Start children, the Fort Peck project--because the local welfare agency refuse to supply a list of Medicaid siblings--and the Danville project--

because they decided they had neither the time nor the resources for recruitment. Those projects that did engage in outreach generally focused on siblings; this goal of reaching siblings was determined by practicality. Applications of Head Start children could be used to identify non-Head Start siblings whose parents were probably amenable to enrollment of the sibling because the Head Start child was already receiving services. Head Start projects that did not concentrate on siblings used such documents as the local welfare census to obtain names of potential EPSDT enrollees.

Many projects facilitated their outreach efforts by seeking to enroll previously Medicaid certified, non-Head Start children in EPSDT. Unfortunately, Head Start projects were less successful in getting their own children Medicaid certified. This difficulty emphasizes the negative effect of the discrepancies in eligibility requirements for Head Start and Medicaid.

To alleviate this difficulty, Head Start enrollment could become the basis for automatic Medicaid certification. Should Head Start/Medicaid eligibility become simultaneous, the EPSDT would be more effective, and the Head Start projects would be more likely to be reimbursed, if their services are covered by the state plan.

Once the names of potential enrollees are obtained, Head Start staff must employ outreach methods to actually recruit non-Head Start children. The most effective outreach was accomplished by the Parent Involvement Component. The staff, the parents, and community people who comprise this component have experiential knowledge of the structures and psychology of the families of potential enrollees and are thereby in the best position to be successful recruiters. It should be recognized that any parent involvement is the most eloquent statement in support of EPSDT, and that wherever possible, especially in light of adult mistrust of government agencies, Parent Involvement Component activity should be encouraged and strengthened.

Other outreach methods employed were less successful, with door-to-door canvassing the most effective after Parent Involvement Component activity. Other potential methods: mass media, community organizations, telephone, etc., tended to be used less frequently. Bilingual approaches fell into the overall pattern discussed above with even less frequent use of non-personal contact methods.

Follow-up

The success of the EPSDT program is largely dependent upon follow-up which includes tracking (relating services received to requirements) and verification (insuring that the required services are received by the child). As might be predicted, services to Head Start children were tracked and verified more completely than those to non-Head Start children. A reason for this is that Head Start is the responsible agency for its own, while it often shared responsibility for non-Head Start children with public agencies. On-site observers rated tracking good to excellent for Head Start children in approximately 80% of the projects, but these observers rated tracking good to excellent for non-Head Start children in approximately 40% of the projects. Not surprisingly, similar observations were made with regard to verification of Head Start and non-Head Start children.

In the area of recordkeeping, Head Start children again have a better showing. Although OCD guidelines specified that individual records be maintained for all children, Head Start maintained more extensive records for its own children. Among the reasons given in questionnaire responses for inadequate recordkeeping is an aversion to paperwork, especially when it is added to staff members' regular duties and when the staff members are given neither specific recordkeeping training nor efficient forms.

The Head Start/EPSDT Collaborative Effort was initiated to demonstrate that more Medicaid certified children would receive EPSDT benefits through Head Start recruiting and administrative activities. Unfortunately, Head Start efforts at securing certification for participating children, especially for new, non-Head Start children, were very minimally effective: averaging 6% for the non-Head Start children and 31% for Head Start children.

V. CHARACTERISTICS AND PREVIOUS CARE STATUS OF PARTICIPANTS IN THE HEAD START/EPSDT COLLABORATIVE EFFORT

A. CHILDREN PARTICIPATING IN THE COLLABORATIVE EFFORT

Nationally, the Head Start projects provided services during the year to 74% of the planned service population; the selected projects showed a similar pattern as they reached 72% of their planned population.* There was a national turnover or drop-out of approximately 9,791 or 19% of the total children served, regardless of enrollment status. With regard to non-Head Start children, the pattern probably indicated that many projects failed to track this particular group through all aspects of screening, diagnosis, and treatment.

In reporting participation during the year, several selected projects reported more service to non-Head Start children than planned. However, in all cases, comparable numbers of intake forms were not submitted. And in one case--Worcester--service to non-Head Start children consisted of simply informing the Head Start parent, at home interviews, that siblings were also eligible for EPSDT. This project did not complete intake forms or identify siblings of non-Head Start children who participated at intake, nor did it attempt to insure linkage or follow-up for the non-Head Start child. Medford reported serving 1,650 non-

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*The material herein was based on the experiences of 120 projects and 18 selected projects which submitted Intake and End-of-the-Year Status forms.

Head Start children but only submitted 45 intake forms for this group.

Discussion on Participation

The variations noted in estimation and service totals for participating children are explained as follows:

- The projects did not receive clear instructions from their respective regional offices as to the priorities and objectives of the collaborative effort.
- Many projects saw their function as providing public information rather than providing or arranging for direct services, which required additional manpower. Paterson, New Jersey is an example of a project with a large planned goal--nearly 5,000--which redefined its responsibility for service and submitted intake forms on only 152 children.
- The perception of the project staff prior experiences in preparing grant applications and proposals may have influenced the way they estimated for planned participation. However, the estimates do not seem to have been an important factor in funding for the collaborative effort. Some projects presented low outreach estimates of service (10-50 children, for example) and still received funding from OCD.
- Weaknesses in some of the grant applications is another factor. Many projects reported that they were prepared hastily. Some projects defined clearly how their estimates were obtained--from census information, welfare rates, etc.--and carefully detailed their outreach strategies, but many proposals gave no rationale for how the service estimate was determined. In many cases, it appeared that projects either misunderstood their roles or failed to understand what the planned service entailed.

- The service estimates for Head Start children were more realistic than for the non-Head Start population.* This pattern is logical because most projects simply reported their funding level. However, many projects had difficulty in making assessments of the number of non-Head Start children in need of service. Many proposals limited planned service to siblings. Others gave estimates of the number of children on welfare in the community but did not appear to have plans to serve or reach all these children.

Although conservative estimates of participation were most likely to be achieved, underestimaters should not necessarily be considered more effective in meeting their more limited goals.

It is interesting to note that of the 38,417 children who had completed intake, only 15% were non-Head Start, and 50% of these were siblings. The high incidence of siblings reflects a general policy to recruit non-Head Start children from Head Start applications. The vast majority of all non-Head Start children were Medicaid certified.

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*Only Regions I,II, and V, with higher concentrations of urban populations, had planned to serve more non-Head Start than Head Start children. Perhaps the greater number of low-incom Head Start eligible families and the tendency of urban proje s to utilize community resources accounts for this phenomena. n regions where few outside resources were available, service estimates tended to be more modest.

B. MEDICAID STATUS OF PARTICIPATING CHILDREN

Although only 35% of children served during the first year of the collaborative effort were reported as Medicaid eligible, 49% were eligible by the end of the year. At intake, 37% of the Head Start children and 35% of the non-Head Start were Medicaid eligible; 37% and 84%, respectively, were eligible by the year's end.

Regional variation of the percentage of Medicaid eligible children compared to participation during the year and at intake might be attributed to:

- Differences between the national poverty guidelines which establish the eligibility income levels for participation in Head Start and the state Medicaid eligibility standards.
- Differences in definition of the categorically and medically needy. This variation in state Medicaid plans may be reflected here.
- Differences among programs in recruiting policies to enroll Medicaid eligible children; some accepted any child within the poverty guidelines or the 10% addition into their programs; others did not.

Medicaid Status Cumulative/End of Year

The probability that Medicaid eligibility was a highly unstable status and the turnover rate within the individual projects probably accounted for the decrease in the number of Medicaid eligible children by the year's end. Changes in eligibility status disrupted the smooth delivery of services. For instance, a child classified as eligible for EPSDT and referred for screening might become ineligible by the time of treatment. Clearly, not all potentially eligible children were finally certified.

Except in Region IV, the number of children classified as unknown decreased during the year while the number of non-eligibles increased. This trend suggests a major effort by the projects to determine Medicaid status.

C. MEDICAID CERTIFICATION STATUS OF PARTICIPANTS

Certification differed from eligibility in that it referred only to those children actually enrolled in Medicaid, not to those potentially eligible; only 88% of the Medicaid eligible were in fact certified during the program year.

Variation at the regional level with respect to the relation of certification to eligibility in the Head Start and non-Head Start populations may have reflected either differences among projects in their eligibility screening and certification procedure or their knowledge of the state Medicaid eligibility requirements. Some projects may have reported as Medicaid eligible only those children certified at the time of intake; whereas others might have reported all uncertified children believed to be eligible but later found to be ineligible. Additionally, the idiosyncracies of certification procedures most likely hampered and complicated certification and may have discouraged potentially eligible children from applying for Medicaid. Head Start involvement in certification aid ranged from staff members providing information and arranging transportation to staff members making personal appearances, assisting in preparation of documents, and setting up appointments.

An analysis of Certification and Total Participation data show that 49% of all children participating in the collaboration were Medicaid certified. At the regional level, the percentage of cumulative certification to total participation ranged from 24% (Region VI) to 77% (Region X).

A comparison of Medicaid certification status prior to intake and Medicaid eligibility at intake revealed that 92% of all eligible children had had prior certification (91% in the selected projects and 92% in all other projects). Ninety-seven percent of eligible Head Start children had been certified prior to entering the program. Both patterns held across all regions.

Of all children remaining in the program or in contact with the program at the end of the year, 44% were Medicaid certified. Regional variation ranged from a certification rate of 19% in Region VI to 72% in Region X. For the Head Start population, the range was from 16% to 62%. This variation might have reflected individual service patterns regarding Medicaid eligible children served by the Head Start projects.

Of the non-Head Start children certified prior to the program, over 50% (2,658 out of 4,541) were siblings of Head Start enrollees. For the selected projects, the proportion of non-Head Start children who were siblings of Head Start enrollees increased to 71%. Notable differences existed in Regions I, III and IMPD projects where the greater proportion of non-Head Start children consisted of non-siblings.

D. PREVIOUS HEALTH CARE: SCREENING OF HEAD START PARTICIPANTS

A contrast of previous health care (both screening and treatment) received by both Head Start and non-Head Start children with health care received during the program year measures the impact of the collaborative effort. The data for previous health care, collected from intake forms completed by the projects is necessarily related to the parental ability to recall the child's health care history.

On the national level, 22% of the Head Start children had been enrolled previously in Head Start. The largest number of children carried over from the previous year occurred in the IMPD projects, where over one out of three Head Start children had been enrolled in Head Start previously.

The importance of prior Head Start enrollment lies in Head Start responsibility under the Head Start Program Performance Standards to provide health screening for all its enrollees. That Head Start was an effective health services provider was demonstrated by the higher level of screening among previously enrolled Head Start children. Nationally, 92% of the previously enrolled children had received screening as compared to 63% of non-previously enrolled who had been screened; the selected project percentages were 79% and 45% respectively. The IMPD projects were the principal deviants, with respective figures of 56% and 52%.

Contrary to expectation, Medicaid certification (41% of Head Start children participating in the collaborative effort) did not strongly influence the receipt of screening services. Nationally, 71% of the Medicaid certified and 70% of the non-Medicaid certified received screening. In the selected projects the majority of previously enrolled Head Start children had been screened prior to intake, although there was marked deviation in the individual projects, from only 20% in Lubbock to 100% in five projects.

E. PREVIOUS HEALTH CARE: TREATMENT RECEIVED BY HEAD START PARTICIPANTS

A profile of treatment (medical, dental, mental health, and nutritional) received by Head Start children during the year prior to enrollment through the collaborative effort yielded the following information:

1. Medical Services

In the national Head Start sample, 5,500 (10% of the participating population) received medical treatment in the year prior to enrollment. The selected projects had a consistent showing. Throughout the regions, however, percentages ranged from 8% to 28%. Similarly, the individual selected projects displayed significant discrepancies: few or no children in Tom's River, Lubbock, and Fort Peck and 46 of 132 children in Medford.

Whereas nationally, Medicaid certification status played no significant role in the receipt of medical care, Medicaid certified and eligible children in the selected projects received more treatment than those classified as other. However, one factor that may account for the impact of classification both in the selected projects and in the regions which had different patterns is that State Medicaid plans differed in the availability of treatment services. These differences would govern the receipt of services by the Medicaid certified.

2. Dental Services

Nationally, approximately one out of three and in the selected projects, approximately one out of four received prior dental screening/treatment. Region VIII recorded a high at 58% and Regions I and V a low at 23%. A similar range occurred in the selected projects: 118 out of 119 in Springfield and 2 out of 231 in Lubbock. Further, nationally those classified as Other Medicaid status received more dental care than the Medicaid certified and eligible but not certified.

3. Mental Health

Only 6% of participants, nationwide, received mental health services; Region I had the lowest percentage--2%--and the IMPD projects had the highest--22%. Interestingly, the average rate in the selected IMPD projects was only 1%, perhaps reflecting the lack of resources in these areas. For the selected projects as a whole, the rate of mental health services prior to EPSDT participation was 50%, with a variation of from no children in three projects to all children in Springfield.

Once again, Medicaid status had no effect nationwide in that the other or unknown status had a slightly higher showing than the eligible and certified.

4. Nutritional Services

Nutritional services were received by only 3% of the Head Start children nationally, and 1% in the selected projects. The IMPD regional data showed 24% but the IMPD selected projects showed a less frequent receipt of services (in explanation, two of the three selected IMPD projects are in Montana which has no provision for nutritional services in its state plan).

F. PREVIOUS HEALTH CARE STATUS OF NON-HEAD START CHILDREN

Data from the projects concerning non-Head Start children revealed the following:

1. Screening

73% of the national total of 6,002 non-Head Start participants were Medicaid certified and 66% were siblings. Of these, 59% were screened prior to participation. In the selected projects, 82% of the non-Head Start children were certified and 75% siblings; all the non-certified were siblings.

Of the total, 48% were screened prior to enrollment, 90% of whom were certified and over half of whom were siblings. Only 75%, by comparison, of those screened nationally were certified.

2. Medical Treatment

One in five non-Head Start children were treated prior to participation, 80% of whom were Medicaid certified and over half of whom were siblings. The selected projects had lower figures, with 8% treated; Medford had the highest percentage with 49%.

3. Dental Services

Compared to the one out of three Head Start children who received dental services, one out of five non-Head Start children, nationally, received dental services as did one out of four in the selected projects. The majority, both nationally and in the selected projects were Medicaid certified. The overwhelming majority in the selected projects were siblings (except for Baltimore where no non-Head Start children in this category were siblings) and about half across the nation were siblings.

4. Mental Health Services

Nationally, whereas 6% of the Head Start population received mental health services, only 3% of the non-Head Start children fall into this category (the IMPD projects, however, indicated 11%). The selected projects fared better with 7%; the high incidence of Medicaid certification in the selected projects (56 of 58) may have been a relevant factor. Further, 55 of the 58 were from Paterson and nearly all were siblings as well as certified. Across the regions, nearly all non-Head Start children were Medicaid certified and most were siblings. In contrast, Medicaid certification played little role for Head Start children.

5. Nutritional Services

Nationally, 4% of the non-Head Start participants received prior nutritional services; more than 75% were classified Medicaid certified or eligible, and most were siblings. In the selected projects, Paterson again accounted for the bulk of the children receiving services (54 of 56). As with mental health, nearly all of these children were certified and siblings.

VI. INDICATORS OF EPSDT PERFORMANCE

Introduction

A significant task for this evaluation study was to ascertain the effectiveness of the Head Start projects in obtaining EPSDT reimbursable services for Medicaid certified children--both Head Start and non-Head Start--and for non-Medicaid eligible children, to determine the extent to which health services were provided or obtained in relation to the children's Head Start enrollment status.*

In order to accomplish this task, several indicators to measure effectiveness were established within the following parameters: (a) the extent to which children received various health and medical services this year compared to the number who received such services prior to the collaborative effort; and (b) the relationship, if any, between the numbers reported and Medicaid certification and Head Start enrollment status. These indicators were based upon the assumption that increases in the numbers of children receiving health services, particularly through EPSDT, can be attributed to the collaborative effort.

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*Detailed Tables (XVIA through XVIE2) are available in the Final Report.

Children Screened During Program Year

Aggregate Totals

The total number of children screened increased fourfold from the twelve month period immediately prior to the Head Start/ EPSDT Collaborative Effort as reported by 147 projects participating. Of the 95,997 children screened nationally, 86% were enrolled in the Head Start program itself compared to 90% previously. For the 23 selected projects submitting data, there were 7,424 children reported as screened, compared to 2,616 previously, an increase of 3 to 1, and 92% of these were Head Start enrollees.

All regions except Region III reported increases in the total number of children screened that, when compared to the previous year, were comparable to or greater than the national ratio of 4 to 1. Most of the percentage increase in the number of non-Head Start children screened this year can be accounted for by the gains in Regions IV and VI.

Selected Projects

There was a threefold increase (6,883/2,616) in the total number of Head Start children screened this year in the selected projects as compared to the number previously screened. The largest number of Head Start children screened was reported by Cleveland (2,456).* For projects that had reported previously, the greatest percentage increases were in Cook County, East St. Louis, Danville, Lubbock, Amarillo and Billings. On the other hand, three projects--Baltimore, Springfield and Eugene--reported the same or a decrease in the number of children screened this year.

Only 34% of the Head Start children screened had been previously enrolled in the program. This incidence was higher than the 29% of previously enrolled Head Start children who had been screened prior to the collaborative effort. Baltimore reported that almost 50% of the Head Start children screened this year had been previously enrolled, while seven projects reported less than 5%.

There is no clear indication whether Medicaid certification had any bearing on the total number of Head Start children screened, since 50% of these children (3,470 out of 6,883) were Medicaid certified and over 49% were either ineligible for Medicaid or of unknown status. Thus, only one-half of the Head Start children screened could have possibly received such services through the EPSDT system.

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*Cleveland, having by far the largest enrollment, often accounts for the vast majority of children in many categories in the following discussion.

Of the projects reported, there were 541 non-Head Start children screened this year, an increase of less than 50% from those reported screened prior to the collaborative effort. The majority (65%) of the non-Head Start children screened were siblings and, for 7%, their kinship relationship to Head Start children was "other" or not known. Most of the non-Head Start children screened (500 out of 541) had not been previously enrolled in Head Start. For these non-Head Start children, Medicaid certification may have influenced the receipt of screening services, given that a greater proportion of them were Medicaid certified as compared to the Head Start children. Of the Medicaid certified group, the majority (62%), were siblings of Head Start enrollees.

Children Completely Screened

Aggregate Totals

Nationally, 31% received the complete package of screening services as recommended by the local Head Start Health Advisory Committee. For the selected projects, 70% received complete screenings. (Either selection bias or the sensitivity of the projects to completing the screenings because of their special status may have accounted for this wide variation.) Head Start children were by far the majority (81%) of those children reported as completely screened. However, only 29% of the Head Start children screened had complete services--24,884 out of 82,782.

The proportion of non-Head Start children who had complete screenings nationally was slightly higher at 34%. Three regions--Regions II, VII, and X--greatly exceeded this percentage at 50%, 55%, and 50% respectively.

Selected Projects

The Head Start children enrolled in the selected projects usually received complete screenings, representing 73% of the total screened. Moreover, 17 of the 22 projects reporting indicated even greater proportions of completely screened Head Start children than the average cited above, with Amarillo stating that all of its 626 children were in this category and Springfield, 114 out of 117.

For non-Head Start children, 73% had complete screenings, and nine of the sixteen projects reporting indicated that a majority of their Head Start children had been completely screened. In Paterson, where all non-Head Start children were completely screened, three out of four were siblings and over 95% had not been previously enrolled in Head Start. For Medicaid, 89% (331 out of 398) were certified and the majority of these children (283 out of 331) were siblings.

Screening Incomplete/Follow-up Required

Aggregate Totals

Follow-up services were required for the majority of children screened nationally (68%) because such services had not been completed. In contrast only 29% of the total children screened in the selected projects required follow-up services. The data is insufficient to determine the nature of screening services still needed. Also, there is no information regarding the relationship between the availability of a full range of screening services and extent of completion, or the impact of program management (length of time required to complete screening and subsequent preparation of forms, etc.).

The rate of incomplete screenings was much lower for non-Head Start children nationally at 49% compared to 69% for Head Start children. Interestingly, the IMPD projects reported only 1% of their non-Head Start children as having incomplete screenings.

Selected Projects

About 28% (1,993 out of 6,883) of the Head Start children screened in the selected projects required follow-up services. 69% had not been previously enrolled in Head Start and 53% were Medicaid certified.

Eleven projects reported substantially lower proportions of Head Start children receiving incomplete screening. For these projects, the majority or all of their Head Start children requiring follow-up had not been previously enrolled. In this instance, their behavior did not differ from other projects having greater numbers of Head Start children needing follow-up.

Only 26% of the non-Head Start children screened required follow-up services, and most of these (136) had not been previously enrolled in Head Start. Nine of the 16 projects reporting stated that a majority of their non-Head Start children had complete screenings. Less than half (41%) of those children requiring follow-up were siblings of Head Start enrollees and, of the total number of non-Head Start children in this category, 82% were Medicaid certified.

Children Diagnosed/Evaluated

Aggregate Totals

There were 9,197 children who received diagnostic or evaluation services during the program year, of which 85% were currently enrolled in Head Start. For the selected projects, 1,890 were reported to have received these services and 94% of these were Head Start children.

No information is available to determine whether the diagnostic services received were as a result of the screening. However, if such assumption can be made, then less than 10% of children screened nationally were also diagnosed, and for the selected projects, this percentage rose to 25%. However, caution should be exercised in considering this data since there is no evidence of a sequential relationship between screening and diagnosis.

According to recent hearings before the House Subcommittee on Oversight and Investigation (October, 1975)* only 15% (1.9 million of the 13 million children eligible for EPSDT) had been screened by 1974. Of these, nearly one-half were found to need additional diagnosis and treatment services. Therefore, the Head Start projects appear to be much lower than the national experience in this regard. All regions, except Regions III, VI, and VII which reported much lower percentages at 44%, 7%, and 4% respectively, followed the national pattern in relation to the proportion of children diagnosed compared to those screened.

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*Op. cit.

Selected Projects

Of the Head Start children screened, 26% (1,791 out of 6,882) received diagnostic services, and Cleveland accounted for over 50% of this group (975 out of 1,791). Of the Head Start children diagnosed, 89% had been previously enrolled in the program.

Less than half (47%) of the total number of Head Start children who received diagnostic services were Medicaid certified, which means that the cost for these services was most likely borne by the family or by the program itself. Many of the projects individually reported greater proportions of Head Start children as Medicaid certified. For example three of them--Trenton, Paterson and Springfield--stated that all their Head Start children receiving diagnostic services were Medicaid certified.

Only nine projects reported non-Head Start children being diagnosed as compared to the 21 projects reporting Head Start children in this category. A total of 99 non-Head Start children were diagnosed among the nine projects.

Children Treated

Aggregate Totals

On the national level, 10,799 children were reported as treated during this year. This represents almost 11% of those screened, but again there is no evidence that such services were rendered as a result of screening or diagnosis. Moreover, a greater number of children were treated than diagnosed/evaluated. This finding most likely reflects traditional medical practices rather than inaccurate reporting, since medical personnel tend to consider diagnosis and treatment as one service with the greater emphasis upon treatment, and since both are usually provided at the same time.

It is probable that many children, particularly those with acute symptoms (colds, stomach ailments, fractures, etc.), were referred directly for treatment without an antecedent diagnostic examination. Telephone inquiries to a few projects substantiated that they did indeed refer children directly for treatment either because the medical problems were acute or because the condition had been diagnosed and/or under treatment prior to the collaborative effort.

Of the children reported as treated, 81% were Head Start enrollees. For the selected projects, 2,103 children were treated, of which over 96% were enrolled in Head Start at that time.

Selected Projects

In the selected projects, 2,008 Head Start children, or 30% of those screened, received treatment. Eugene, which had indicated 15 Head Start children diagnosed reported no treatment. Cleveland's Head Start population (1,324) constituted the majority of the children treated; the next highest was Amarillo with 148. Most of the projects (16 out of 21) reported that the majority of the Head Start children treated had not been in the program previously. The majority (56%) of Head Start children treated were either ineligible for Medicaid or their status was unknown.

As was the case with diagnostic services, few (95) non-Head Start children were treated, and these constituted 17% of the total non-Head Start population screened this year. Cleveland again accounted for the majority (58) of the non-Head Start children treated in the 13 reporting projects. Most of the non-Head Start children (91 out of 95) had not previously been enrolled in Head Start. The majority of the non-Head Start children (84%) were Medicaid certified and most (67) were siblings.

Children Treated by Type of Unit of Service

Children Treated by Type of Unit of Service refers to the frequency that specific treatment services were provided:

- Acute/Chronic refers to treatment services provided for medical problems which were episodic or ongoing in nature but did not require surgical intervention or corrective devices.
- Surgical/Corrective refers to the application of surgical procedures (in or outpatient) or prosthetic devices (eyeglasses, hearing aids, orthopedic appliances) to alleviate a medical problem.
- Other refers to treatment services provided but not covered under the above two categories.

Aggregate Totals

There were 28,655 units of treatment services provided to children nationally during the year, which would suggest that on the average each child treated received 2.6 units of services.

28,655 (treatment units = 2.6 treatment units per child).

10,799 (children treated).

Acute/Chronic treatment was by far the most predominant type of service provided at 83% of the total (24,015 out of 28,655). Surgical/Corrective treatment was the least prevalent service provided during the year, 2,149 units of service. For Other units 2,491 such services were reported.

Most (84%) of the acute/chronic treatment units, were provided to Head Start children. At the selected project level, an even greater proportion (95%) of these services was given to Head Start children. Region IV had the highest number of acute/chronic services provided: 40% of the national total, and Region III, the lowest. Interestingly, Region I provided a greater number of these units to non-Head Start children, 1,294 out of 2,397 units reported.

The majority (86%) of the surgical/corrective units and other treatment units (79%) were also provided to Head Start children, both in the selected projects and regionally.

Selected Projects

There were 10,189 units of treatment services provided to Head Start children in the 19 selected projects submitting data. Each Head Start child treated received 5.6 units of service, or double the national rate, with acute/chronic services again th most prevalent (95%), and with only 730 surgical/corrective units and 182 other reported.

The majority (59%) of acute/chronic units went to Head Start children who were previously enrolled in the program. Most (55%) of the acute/chronic units were provided to Head Start children classified as ineligible for Medicaid or as status unknown. Most of these were provided to Head Start children in Cleveland, Amarillo, Appleton, Kingston, and Lubbock. The majority of the remaining projects, 13 out of 19, indicated that the greatest proportion of these units went to Medicaid certified Head Start children.

A total of 730 surgical/corrective units were given to Head Start children in 15 projects. Over half (54%) of these units went to previously enrolled Head Start children, most of whom were in Cleveland. Like acute/chronic services, the majority of surgical/corrective units went to Head Start children reported as Medicaid Other. Nine out of 14 projects provided the majority of these units to Medicaid certified Head Start children.

Eighteen projects reported a total of 182 Other treatment units being received by Head Start children; in eight of the eighteen, none of the concerned children were previously enrolled in Head Start. The majority of the Other treatment services went to Medicaid certified Head Start children.

A total of 448 units of treatment provided to non-Head Start children at a rate of 4.7 units per child, was slightly lower than the rate for Head Start children but much higher than the national average for all children. *Acute/chronic* treatment again constituted the major unit with a frequency of 95%, comparable to that for Head Start children. Only two units of *surgical/corrective* services and nineteen *Other* treatment units went to non-Head Start children.

Fourteen projects reported no *acute/chronic* services to non-Head Start children. Nearly all (96%) of the non-Head Start children receiving such treatment were new to the program. A large majority were Medicaid certified and the preponderant number (333 out of 362) were siblings. Only two projects --Leominster and Appleton--reported *acute/chronic* units of service being received by non-Medicaid certified children not currently enrolled in Head Start. In this group of 33, 18 were siblings. Interestingly, for these two projects the majority of treatment services went to non-Head Start children.

Only Appleton reported *surgical/corrective* services being provided to non-Head Start children. Five projects--Leominster, Cleveland, Appleton, Billings and Medford--reported a total of nineteen units of *Other* treatment services for non-Head Start children, seventeen of which were given to non-Head Start children not previously enrolled in the program. The majority of these services went to Medicaid certified children, of whom over 78% were siblings of Head Start children.

Children Requiring Follow-up

Aggregate Totals

Less than half (9,290 out of the 19,996) of the children diagnosed or treated nationally required follow-up services.

The vast majority (89%) were at that time enrolled in the selected projects, and 43% of the children diagnosed or treated during the year needed further services. Regionally, there was general adherence to the national pattern except in Region VII, which had a much lower incidence of children needing follow-up (23%), while Region IX reported nearly 60% in this category.

Selected Projects

In twenty-two selected projects 3,799 Head Start children received diagnostic or treatment services as part of this year's collaborative effort. Of these, 47% required follow-up services. Eight projects reported greater proportions of children needing follow-up than the average rate for the selected projects. Medford and Eugene, on the other hand, indicated that most or all of their Head Start children diagnosed or treated did not need follow-up.

Most (64%) of the Head Start children needing follow-up had not been in the program previously; Fort Peck was the only project with a greater proportion of previously enrolled. Less than half of the Head Start children (853 out of 1,813) were Medicaid certified, although most of the projects reported that over 50% of their Head Start children needing follow-up were certified.

Only 28% (56 out of 194) non-Head Start children diagnosed or treated during the year required follow-up services. Of the fourteen projects reporting non-Head Start children diagnosed or treated, five stated that none of the children needed follow-up. Fifty out of the 56 non-Head Start children in this group had not been in the program previously. A majority (42 out of 56) were Medicaid certified and siblings of Head Start enrollees (33 out of 56).

C. RECEIPT OF DENTAL SERVICES

Children Receiving Dental Services

Aggregate Totals

Nationally, 48,897 children were reported to have received dental services during this year, a fourfold increase over the receipt of such services prior to the collaborative effort. The Head Start projects undoubtedly made a major effort to ensure that children involved in the program obtained dental care. This concentrated effort can be attributed primarily to two factors: compliance with Head Start Performance Standards, and a heightened sensitivity to obtaining health services for children.

Of the total group of children receiving dental services, 87% were Head Start enrollees. The greatest increases from the previous reporting period occurred in Regions I, IV, and V with ratios of seven to one, six to one, and six to one, respectively; however, in Region III, the number of children receiving dental services decreased 19% from the previous year.

Selected Projects

Twenty-two projects reported a total of 6,167 Head Start children receiving dental services this year. This is a fivefold increase from the previous year (nineteen projects at that time). Ninety-three percent of these children were Head Start enrollees.

The majority (627) of the Head Start children receiving dental services had not been previously enrolled in the program. Two projects--Trenton and Eugene--indicated that none of their Head Start children were previously enrolled, while three projects--Baltimore, Cleveland and Fort Peck--reported that the majority of their children had been.

One half (50%) of the Head Start children were Medicaid certified, but an almost equal number were either ineligible or of unknown status. Fifteen projects reported a majority of the Head Start children receiving dental services as Medicaid certified. Seven projects had a majority of their Head Start children recorded as Other, with Fresno indicating that all of its children were in this category.

Sixteen projects reported a total of 366 non-Head Start children receiving dental services. This represents about twice as many as reported previously (nine projects reporting at that time), but the gain is not as great when compared to the increase for Head Start children or the national average. The highest number of non-Head Start children in this category were accounted for in Cleveland (225), while Cook County and East St. Louis were the lowest with two each.

Of the 16 projects reporting, eight stated that none of their non-Head Start children had been in the program previously. In fact, no previously enrolled children were included among the vast majority of non-Head Start children receiving dental services (339 out of 366).

About 90% of the non-Head Start children in this category were Medicaid certified, and the majority of these (280 out of 328) were siblings of Head Start enrollees. In Baltimore, however, all of its Medicaid certified non-Head Start children were not siblings.

Children Treated by Types of Units of Service

Aggregate Totals

The projects were asked to indicate the frequency with which children participating in the collaborative effort received dental *assessment*, i.e., formal screening as preventive care, and *treatment* services. Nationally, the total units of dental services provided were 53,683, of which *assessment* constituted the greater proportion, 56%. However, for the selected projects, the total units provided were 15,073, of which 56% were *treatment* services. There is no information to account for this difference except the probability that the selected projects may have placed special priority on obtaining treatment services under the assumption that these had greater health significance.

The number of dental service units provided per child is not as great compared to the medical services average. Nationally, each child received a little over one unit of dental services and in the selected projects the rate increased to 2.3, again reflecting more concentrated activity by the projects.

Head Start children received the vast majority, 89% of the assessment services provided nationally. The largest number of units given in a region occurred in Region IV with 9,375 units reported (33% of the national total), but Region III had the greatest proportion of assessment units being provided to Head Start children (1,060 out of 1,066). Region X meanwhile provided more dental assessment services to non-Head Start children.

For dental treatment services, Head Start children again received the greater proportion (89% of the units provided). Region IV again reported the largest number of units provided, while Region III had the largest number of units relative to Head Start children.

Selected Projects

Twenty-two projects provided 14,066 units of dental services during the year to Head Start children, at a rate of 2.3 per child. Treatment services were more prevalent, although nine projects provided a greater proportion of dental assessment to Head Start children.

Of the 6,117 dental assessment services provided, 62% (3,853) went to Head Start children not previously enrolled in the program. Three projects--Leominster, Trenton, and Eugene--reporte that none of their Head Start children were previous enrollees; however, four others reported previous enrollees in the majority.

One half of the Head Start children receiving dental assessment were Medicaid certified, and the rest (2,960 out of 6,117) were primarily Medicaid Other. Four projects--Trenton, Paterson, East St. Louis, and Springfield--had 80% or more of their Head Start children listed as Medicaid certified. Lubbock, Cleveland, Kingston and Amarillo had Medicaid Other in the majority.

Cleveland had the largest number of dental treatment services provided (3,692 out of 7,949). Amarillo was next with 589. The majority of these services were provided to children not previously enrolled in Head Start although in Cleveland 76% had been previously enrolled.

49% of the dental treatment services went to Medicaid certified Head Start children. In Paterson, and Springfield all of the Head Start children receiving dental treatment services were Medicaid certified. Cleveland, Kingston, Lubbock, Amarillo and El Centro indicated that a majority of the Head Start children were either ineligible or of unknown status.

Non-Head Start children were provided with 1,007 units of dental services (with a total of sixteen projects reporting), for a rate of 2.1 per child. Treatment was again the most predominant service provided, but for non-Head Start children, the percentage rate was higher at 70% than that reported for Head Start enrollees. Of the 364 dental assessment services provided, 93% were given to non-Head Start children not previously enrolled in the program. A great majority (86%) of the dental assessment services went to Medicaid certified non-Head Start children, the majority of whom were siblings. Most of the non-siblings were also Medicaid certified, but the majority of non-Head Start who were Medicaid Other either had no kinship relationship to Head Start children or were of unknown familial relationship.

Eleven projects reported a total of 643 dental treatment services provided, of which 94% went to non-Head Start children not previously enrolled. Seven projects stated that none of the non-Head Start children in receipt of dental treatment were previous enrollees.

Most of the dental treatment services were provided to non-Head Start children who were Medicaid certified (603 out of 643), and 79% were siblings. Cleveland accounted for 455 of the Medicaid certified non-Head Start children, of whom 451 were siblings.

Cases Completed

Aggregate Totals

Only 40% of the children receiving dental services had completed services. Of these, 90% or 18,104 were Head Start children. or the selected projects, the completion figure was 91%. Two regions had rates of completion which far exceeded the national average--Region III with 89% and Region IX with 60%--while two other regions had relatively low percentages--Region I, 26% and the IMPD projects, 37%.

Selected Projects

All 22 projects reported cases of dental services completed, for a total rate of 90%, or 5,591 out of the 6,167 Head Start children receiving such services. Of these, 38% or 2,156 of the children were previously enrolled in Head Start. All projects but Cleveland had, as a majority, Head Start children who were not previously enrolled. Forty-nine per cent of the cases completed were of Medicaid certified Head Start children.

Almost all the non-Head Start children receiving dental services (357 out of 366) had completed cases comparable to the experience of Head Start children. For the completed group, a majority (328) were not previous enrollees. Eight projects, however, reported a majority of previous enrollees. Again, a major portion (87%) of the non-Head Start children with completed cases were Medicaid certified and the majority of these were siblings (272). Baltimore had the greatest number of non-siblings not part of the Head Start program and they were Medicaid certified.

Cases Requiring Follow-Up

Aggregate Totals

The majority of dental services cases required follow-up: 59% or 28,908 out of 48,897. Of these, 83% were Head Start children. For the selected projects, 9% or 638 out of 6,533 children receiving dental services needed futher assistance. Three regions exceeded the national average--Region I at 73%; Region II at 67%; and Region VIII at 60%. In Region III, only 10% of the children receiving dental services needed follow-up.

Selected Projects

Few of the Head Start children (10%) receiving dental services in the selected projects needed follow-up. The largest number of Head Start children reported in this category occurred in Dayton (176), with the next highest being Fort Peck (122). Interestingly, Cleveland, which had the highest number of Head Start children treated (2,284), stated that none needed follow-up.

Four out of five children needing follow-up had not been previously enrolled in Head Start. This pattern held true for all projects except Baltimore and Fort Peck, where the majority of Head Start children who needed follow-up were previous enrollees. Approximately 60% of the Head Start children who needed further services were Medicaid certified.

Seven projects reported a total of 25 non-Head Start children needing follow-up, less than 1% of the total number of such children receiving dental services. Of this group, 20 were not previously enrolled and 17 out of 25 were Medicaid certified.

D. RECEIPT OF MENTAL HEALTH SERVICES

Children Receiving Mental Health Services

Aggregate Totals

Nationally, 9,623 children received mental health services, compared to 2,450 previously reported, representing a fourfold increase. Of this group, 92% were enrolled in Head Start. For the selected projects, 3,014 children were reported to have received mental health services, compared to 290 previously, a fourfold increase.

A majority of the regions, eight out of eleven, reported at least twice the number of mental health services as compared to those provided prior to the collaborative effort. Two regions--I and IV--had increases higher than the national average, at 1100% and 400% respectively. Region III, however, reported a decrease in the number of children receiving mental health ser vices this year, while Region X registered an increase of only 1%.

The greatest proportion of Head Start children relative to non-Head Start children receiving mental health services this year was in Region V (340 to 3). Region VII had no non-Head Start children receiving mental health services. Region X had a lower differential between Head Start and non-Head Start in this category (64 to 12). Region IV had a marked increase of non-Head Start children served compared to those reported prior to the demonstration program (32 to 575). Regions V, VII, and the IMPD projects reported fewer non-Head Start children receiving mental health services than those previously reported.

Selected Projects

The total number of Head Start children receiving mental health services increased tenfold compared to prior receipt of such services. The number of projects reporting in this category also increased this year from 15 to 21.* (Cleveland accounted for 70% of the Head Start children reported this year [2,197 out of 2,946]). Fifteen projects had five or fewer Head Start children in this category.

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*Eugene did not report any children in this category.

The majority of the Head Start children, 51%, were previous enrollees. (Cleveland accounted for 1,424 children in this group.) However, nineteen of the twenty-one projects, listed a greater number of Head Start children as not previously enrolled.

Fifty percent of the Head Start children receiving mental health services were Medicaid certified; Cleveland had 1,007 out of 1,446. Slightly more than half of this particular project's Head Start children were Medicaid Other. Thirteen projects had a majority of their Head Start children receiving mental health services as Medicaid certified, and three of them--Paterson, East St. Louis, and Springfield--reported all their Head Start children in this category.

Six projects (as compared to three for last year) reported a total of 71 non-Head Start children receiving mental health services this year, a 12% increase from the year prior to the collaborative effort.

Billings had the highest number of non-Head Start children reported (27) and Leominster was next with 19. Over three-quarters of the non-Head Start children receiving mental health services were not previous enrollees.

One half of the non-Head Start children receiving mental health services were Medicaid certified, and the majority were siblings.

Non-siblings constituted the majority of those non-Head Start children recorded as Medicaid Other.

Children Psychologically Tested/Evaluated

Aggregate Totals

Of the 9,623 children receiving mental health services this year nationally, 92% were psychologically tested. Although the nature or extent of this testing is unknown, it is probable, given such a high incidence, that the tests were primarily an assessment procedure.

The vast majority of the children receiving these evaluations were Head Start enrollees. For the selected projects, 97% of the children served were tested, and 92% of them were part of the Head Start program.

All the regions except Region I reported substantial portions (at least 77%) of the children receiving mental health services as being tested. Except for Regions V and VII, all others indicated that the children tested were predominantly in the Head Start program.

Selected Projects

In twenty projects 98% of the Head Start children served received psychological evaluation. Cleveland was the highest with 2,197 and Billings next, with 148. Paterson, East St. Louis, Fort Peck and Fresno had no more than two each.

Even though the majority (51%) of the Head Start children being tested were previously enrolled, most of the projects indicated a greater number of their Head Start children as not previously enrolled. Over half of the Head Start children tested were Medicaid certified, with 49% cited as Medicaid Other.

Only 41 non-Head Start children received psychological evaluations and these were all in three projects--Trenton, Cleveland and Billings. None of these children had been in Head Start previously. Of these non-Head Start children, 68% were Medicaid certified, and most were siblings. Non-siblings, however, constituted the majority of both Medicaid certified and Other children.

Children Referred

Aggregate Totals

Only 13% of the children receiving mental health services nationally were referred for further services. There is no information regarding the extent that referrals occurred as a result of psychological testing. For the selected projects, the referral rate was much lower at 5%. Head Start children represented 90% of the group referred (1,177 out of 1,260). Five regions--Regions V, VII, IX, X, and the IMPD projects--reported under four non-Head Start children referred.

Selected Projects

Nineteen projects reported a total of 179 Head Start children, or about 6% of the children receiving mental health services this year. Appleton had the highest number of Head Start children referred (45). East St. Louis and Fort Peck did not report any children in this category. Cleveland, with the highest number of children receiving mental health services, reported eight referrals, a rate of less than 1%.

Eighty percent of the Head Start children referred were not previously enrolled; 53% of the 179 referrals represented Medicaid certified Head Start children. In five projects, the majority of the referred children were Medicaid Other.

Only six non-Head Start children were referred for mental health services and these were from Trenton, Cleveland, and Billings. None of the children were previous enrollees, and two out of three were non-siblings who were either Medicaid certified or Other.

Children Counseled

Aggregate Totals

Counseling services were received by 16% of children nationally receiving mental health services. Again, it is not known whether these services were a consequence of psychological testing. For the selected projects, counseling service was provided at a rate of only 4%.

Regions III and X reported considerably higher rates of children counseled relative to the receipt of mental health services--92% and 51% respectively. The rates for the other regions ranged from ten percent to 33%.

Head Start children represented the greater proportion, 89%, of those counseled nationally. For the selected projects, Head Start children accounted for over 90% of the total group counseled. Six regions reported under five non-Head Start children counseled.

Selected Projects

Eighteen projects reported only 4% of the Head Start children who received mental health services also received counseling. Kingston had the highest number with 19, while Paterson and Fresno cited only one Head Start child each.

Almost three-quarters (74%) of the Head Start children counseled were not previous enrollees. Although six projects had no previous enrollees, four others stated that a majority of their Head Start children who were counseled had been previously enrolled.

Of the 157 Head Start children counseled, 56% were Medicaid certified. In 11 projects the majority of the Head Start children were certified and in two--Paterson and Baltimore--they all were.

Only six non-Head Start children were counseled, and they had the same characteristics as those cited for the group that was referred for further services.

Cases Completed

Aggregate Totals

Most of the children (84%) receiving mental health services nationally had completed cases. For the selected projects, the incidence was somewhat higher at 95%. Again, Head Start children were the predominant part of this group. There was wide regional variation in this category with Region III reporting only 9% completed and Region VIII and X reporting 52% and 48% respectively.

Selected Projects

Twenty projects reported that of the 2,946 Head Start children receiving mental health services 91% had completed cases. Cleveland had the highest with 2,175; Springfield, Billings and Appleton followed with 116, 115, and 112 respectively.

Of the Head Start children whose cases were completed, 52% had been previously enrolled. Seventeen projects, however, had a majority not previously enrolled, and none of them reported no previous enrollees.

The Head Start children who had completed mental health services were fairly evenly divided into Medicaid certified and Medicaid Other. Fourteen projects reported a majority of their Head Start children with completed services as Medicaid certified.

Seven projects reported a total of 71 completed mental health cases for non-Head Start children (Kingston reported three in this category even though it had not indicated any non-Head Start children receiving mental health services). Almost three-quarters (74%) of these non-Head Start children were not previously enrolled. Half of the non-Head Start children were Medicaid certified, and of these, 50% were siblings. Non-siblings made up the majority of Medicaid Other.

Children Requiring Follow-Up

Aggregate Totals

As expected from the rate reported for completed cases, only 15% of the children served for mental health purposes needed further services, and the major portion of these were Head Start enrollees (94%). For the selected projects, only 3% of the children required follow-up and Head Start children were in the majority here also. Three regions deviated markedly from this pattern--Regions III, V, and X--where 90%, 64% and 51% of the children receiving mental health services during the year required follow-up.

Selected Projects

Only 5% of the Head Start children receiving mental health services in the selected projects required follow-up services. Kingston and Billings were highest each with 29; Leominster, Paterson, Fresno and Eugene reported no Head Start children in need of follow-up.

Again, almost three-quarters (74%) of these Head Start children had not been previously enrolled. Of the 17 projects reporting, 12 stated that a majority of their children were not previousl enrolled.

About half of the Head Start children requiring follow-up services were Medicaid certified. Nine projects had a greater number of their children as Medicaid certified, and five projects had the majority as Medicaid Other.

Billings was the only project reporting non-Head Start children needing follow-up, listing three in this category, none of whom were previously enrolled and two of whom were Medicaid certified.

E. RECEIPT OF NUTRITIONAL SERVICE

Children Receiving Nutritional Services

Aggregate Totals

Relatively few children received nutritional services nationally, compared to Medicaid dental and mental health services, since only a total of 3,347 children were cited in this category. This total did represent, however, an almost threefold increase from the number reported as receiving such services prior to the collaborative effort. Only Region III registered a decrease from the previous year (75 to 14). The most substantial increases were in Region IX and Region X. Region VI had the smallest increase, 30%. For the selected projects the increase was less than two to one (155 to 99).

Head Start children constituted the overwhelming majority (84%) of children receiving nutritional services, and the rate of increase from the previous year was comparable to the national average. Region IV had a greater increase in non-Head Start rather than Head Start children; Region VII, on the other hand, reported no non-Head Start children served.

Selected Projects

There was also a three to one increase in the total number of Head Start children receiving nutritional services this year (150 to 43). Thirteen projects provided data in this category, an increase of four from the previous year. Over 90% of the Head Start children were not previously enrolled in the program.

A majority (57%) of the Head Start children receiving nutritional services were Medicaid certified. Of the 13 projects reporting, seven had a majority of their Head Start children listed as Medicaid certified, while three had Medicaid Other children in the majority.

Leominster, Trenton, and Cleveland reported only five non-Head Start children as receiving nutritional services this year. The number reported represents a 500% decrease from the previous year. All five of these children were not previously enrolled in Head Start, and most of them were siblings and either Medicaid certified or Other.

Children Referred for Further Assessment/Evaluation

Aggregate Totals

In sharp contrast to the referral rate for mental health services, three-quarters of the children (2,527 out of 3,347) served nationally were referred for further assessment. Six regions--Regions V, VII, VIII, IX, X, and the IMPD projects--reported a much higher number of referrals than the average, with rates of 92%, 95%, 98%, 100%, 97% and 95% respectively. The majority (86%) of children referred were Head Start enrollees (Region VII had no children referred).

Selected Projects

Twelve projects reported that 79%, or 115 out of 150 Head Start children served, were referred for further assessment. Eugene had the highest number with 57, and Kingston was next with 17. All the non-Head Start children receiving nutritional services were referred.

Approximately 92% of the Head Start children referred were not previously enrolled. The majority (62%) of these children were Medicaid certified. In El Centro, however, all Head Start children in this category were Medicaid Other.

Children Treated

Aggregate Totals

A majority (59%, or 1,981 out of 3,347) of the children receiving nutritional services nationally were treated, and the preponderance of these were Head Start enrollees. For the selected projects, there were fewer children treated than those receiving nutritional services (45%).

Three regions--II, III, and VI--reported even higher rates of children treated than the national average at 87%, 78% and 93% respectively. Three others--VIII, X and the IMPD projects--were much lower at 12%, 11% and 10% respectively.

Selected Projects

Nine projects reported a total of 64 Head Start children treated. Cook County was highest with 19. Four out of the total of five non-Head Start children were reported as treated.

Most (85%) of the Head Start children were not previously enrolled and only 73% were Medicaid certified.

Cases Completed/Follow-Up Required

Aggregate Totals

Almost half (46%) of the children receiving nutritional services nationally had completed cases, a rate lower than that reported for mental health. The selected projects followed a similar pattern.

Region III had the highest rate of completion at 93% (11 out of 14). Region II was the lowest at 7%, although it reported more non-Head Start cases completed.

Selected Projects

Ninety-six out of 150 Head Start children receiving nutritional services had completed cases. Again, most of this group (90 out of 96) were not previous enrollees, but in contrast to those treated, the majority (64%) were Medicaid certified. Four of the five non-Head Start cases were completed.

Almost all the Head Start children requiring follow-up were not previous enrollees but, interestingly, the majority (over 60%) were Medicaid Other.

VII. HEAD START/EPSDT RELATIONS WITH LOCAL, STATE AND FEDERAL AGENCIES

Introduction

This section presents a comparison of the Head Start Program Performance Standards and the EPSDT plans of the target states and analyses of the relationships between the selected projects and local, state and federal agencies within the context of the EPSDT institutional framework.*

A. STATE EPSDT PLAN FOR TARGET STATES

All states required to provide EPSDT services since February 1972, have been encouraged to develop a statewide coordinated and integrated evaluation process and health care system for this program. The federal regulations do not require presentation of a formal EPSDT plan by a state for approval prior to implementation as it is expected that the EPSDT program will be a further refinement of the state's Medicaid (Title XIX) plans.

SRS does, however, mandate certain basic provisions for a state EPSDT program and recommends minimum levels of services. The states are required to utilize and/or develop community resources to provide screening and diagnostic services. The federal reporting requirements for EPSDT are designed to insure that a state has developed the appropriate administrative mechanisms to inform eligible families, provide or arrange for screening services and provide or arrange for corrective treatment.

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*Tables X through XV in the Final Report provide greater detail.

Analysis of Findings

Eleven out of the 12 target states in the collaborative effort had prepared a state plan for EPSDT as of June, 1975; and eight of them had distributed the plan. Three had developed a plan but no distribution of the document had been made; and one state, Montana, had no specific EPSDT plan although some services are being provided. Only one state, Ohio, provided definitions for all seven service categories.

Nine out of 12 state plans provided for outreach; seven provided for transportation services; and six for publicity. Seven states delegated operational responsibility for outreach to a governmental agency other than the EPSDT unit while two retained this function.

There was comparability between state screening procedures and those recommended by SRS in five state EPSDT plans. There were gaps or omissions of certain procedures in five other plans.

B. COMPARISON OF HEAD START PERFORMANCE STANDARDS AND STATE EPSDT PLANS

The guidelines for the collaborative effort stipulated that the Head Start projects were required to provide certain minimum health services in accordance with the Performance Standards regardless of the scope of the state EPSDT plan.*

Background

Head Start Performance Standards

In 1973 the Office of Child Development** issued the Head Start Performance Standards as a measure of strengthening the quality of services provided to children and families served by Head Start. The standards established national criteria for performance and built upon seven years' experience of the Head Start program as a demonstration effort.

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* The presentation of the findings is based on the analysis of the plans of all target states except Maryland for which we were unable to obtain written policy regarding the health services package.

**In June 1975 the Office of Child Development revised the Performance Standards to become effective July 1, 1975. However, the standards in effect during the first year of the collaboration, set forth in OCD Notice N-30-364-1-00, were used for the comparison with the state plans.

Requirements of State Medicaid/EPSDT Plans

The regulations issued by SRS in November 1971 for EPSDT mandated state Medicaid plans to provide screening and diagnosis services, and treatment of medical problems for all eligible individuals under 21 years of age. However, SRS regulations for EPSDT did not specify screening procedures. The state Medicaid plan was required to maintain written evidence of its specific screening package. In addition, the federal regulations allowed states to define early and periodicity, thus affecting the frequency by which children received services. During the first year of the collaboration, a minimum package of screening procedures was not mandated, but SRS has been consulting with child health authorities to determine whether such a minimum package actually should be required.

Because the EPSDT regulations allow for standard-setting by the state, enforcement is limited to the provision of services specified in the state plan. Even when individual states specify particular screening units, there is often a wide variation in the type of service rendered due to lack of specification of screening instruments and procedures.

Methodology

The Head Start Performance Standards present an interdisciplinary approach to health services as a means of improving the physical, mental and nutritional status of preschool children. Moreover, the standards require that the local Health Advisory Committee composed primarily of parents of Head Start children be established to assist in planning and evaluating the health program. However, the Policy Council (the parent involvement body) must approve the program. Establishing the Head Start Performance Standards as a baseline, the EPSDT plans for the target states were examined to determine their comparability with these standards.

Analysis of Findings

Health Services

History (medical and developmental). All 11 states required that a history of the child be obtained. However, the type and level of specificity varied with state requirements, ranging from a "brief history" to detailed histories with specification on the permanent medical record. Texas, for example, required that a complete history for birth, prior hospitalization, allergies, bedwetting, and bowel habits be recorded, whereas three states required no differentiation between medical and developmental information.

The implications of the variance are that states in which itemized histories were required, particularly if completion of this detailed history were required on the reporting form, insured that the provider was obtaining a comprehensive history on the child, better enabling him to assess the child's current health and identify possible medical problems. States which required only a "brief history" allowed the practitioner to determine which aspects of the child's history would be obtained. Therefore, different levels and quality of care most likely were rendered relative to the professional concern of the attending practitioner.

Screening. The Head Start Performance Standards presented a list of screening tests and procedures to be given to all children to assess mental and physical health. All the states provided for the basic screening services of growth assessment, vision and hearing testing, and assessment of immunization status. However, many of the other screening tests were labeled optional or recommended only "if indicated" in several states. In New Jersey, Missouri and Ohio, for example, a tuberculin test was performed only if indicated. In addition, Ohio and New Jersey required hemoglobin/hematocrits only if indicated, and New Jersey did not require urinalysis. The conditions whereby these procedures would be indicated were not specified. Again, this failure to specify allowed a great deal of discretion to local practitioners.

Examination of the provisions for vision and hearing tests revealed that only Tennessee, Mississippi, Montana, Texas and Oregon stated the specific screening procedures to be used (e.g., Titinus Telobinocular, or Pure Tone audiometer). The other states merely specified that vision and hearing tests be performed, which might vary from a visual inspection of the eyes to a comprehensive examination. All states except Montana required sickle cell screening, with New Jersey and Ohio qualifying that the screening be performed "as indicated."

Other areas of selected screenings were: six states require lead poisoning screening, and three additional states (California, Oregon, and New Jersey) require it only if indicated. Two states, Mississippi and Montana, make no provision for lead poisoning screening. Four states, New Jersey, Mississippi, Tennessee and Ohio, make provision for intestinal parasites screening where indicated. This pattern may have reflected the prevalence rates of such problems in various regions.

Oregon, Montana, Tennessee, Ohio and Texas make provision for the identification of speech problems. California was the only state which specified the identification of handicapped children. Massachusetts reported exploring the possibility of using its Department of Public Health as an outreach mechanism for those Medicaid eligible children with special needs.

Physical Examinations. The itemization of the physical examination required in the Performance Standards varied from one state to another. For example, New Jersey and Montana required only a physical examination while in Mississippi and California, the physical examination mandated was identical to the Head Start Performance Standards. Of the remaining states, the most commonly mentioned items were examination of ears, eyes, nose and throat.

Immunizations. All states required an updating of immunizations. Neither Missouri, Massachusetts, nor New Jersey specified the required immunizations. Mississippi required these services pursuant to the policies of the Board of Health, but such policies are not specified. Two states, Tennessee and Illinois, will not reimburse for immunization against mumps. Texas and Ohio did not specify immunizations in the narrative of the state plan, but they are reflected in the reporting form and other documents included in the plan.

Nutritional Assessment. All the states with the exception of New Jersey and Illinois made some provision for nutritional assessments. This ranged from a state plan recommending examination of the skin, "which may be of nutritional significance," or anemia testing, to requirements for a detailed examination of a child's dietary habits.

Dental Screening. Although all states provided for dental screening, the level of specifity varied. Some states merely required a "dental screening" or an examination of teeth and gums, whereas others called for thorough examinations, including bite-wing x-rays and prophylaxis. For dental care, the general pattern was to categorize services into the areas of preventive and emergent/therapeutic. Many states did not require that the dental screening be performed by a dentist, and in some states such as Tennessee, a child had to be screened through the Medicaid program before a referral could be made for dental treatment. None of the states defined a dental screening package identical to the Head Start Performance Standards. Rather, many states provided only a dental screening under the EPSDT state plan. If treatment was required the child was referred and additional services were covered under the general Medicaid program. New Jersey and Massachusetts did not outline a treatment program; but Massachusetts reported being in the process of developing sound dental referral mechanisms, and California only mentioned that children be referred for therapeutic attention. A prevalent trend in the area of dental services was the requirement of prior authorization for dental treatment, although this was not true for dental diagnosis and further assessment in Oregon, Missouri (for some services), Tennessee and Mississippi.

The periodicity of dental services differed among state plans. Massachusetts and Ohio provided for dental screenings every six months. Texas performed dental screening every three years unless otherwise requested by the parents.

Dental reimbursement patterns varied and many states did not specify the billing procedure or reimbursement rate. Others specified maximum limits (i.e., Mississippi's $100/child/year), and Tennessee required prior authorization for treatment plans totaling more than $60. Some states, such as Texas, reimbursed according to usual and customary fees. Oregon's plan contains a fee schedule. A complete analysis of the dental reimbursement and treatment provisions was not possible because most of the state plans failed to indicate specific treatment and reimbursement procedures.

Treatment. Examination of provision for treatment requirements revealed no uniform pattern. In part, this reflected the organization and administration of the state EPSDT plan. For example, in Illinois, the screening package was provided for under the Medicheck program (with separate billing and recordkeeping requirements). However, if treatment was deemed necessary, it was provided for and billed to the general Medicaid program. This administrative division of labor and responsibilities complicated the procedure for providers and organizations such as Head Start in their understanding of the program. In addition, states which provided screening through screening clinics (i.e., Texas) referred patients to other providers for diagnosis and treatment, (i.e., traditional providers such as private practitioner). In Texas, billing and reimbursement were administered through the current health insurance contract between the Department of Public Welfare and Group Hospital Services. Texas and Ohio were the only states which listed the provisions of their treatment package, albeit in a general manner. Most of the EPSDT plans did not itemize the benefit package for treatment services.

California's Child Health Disability Prevention Program was limited to screening, and those children in need of treatment were referred to the Medi-Cal program. This new program supplanted the EPSDT program in the state and provided for early and periodic screening of all Medi-Cal eligible children as well as those entering the first grade whose gross annual family income was at or below twice the AFDC minimum base. Therefore Medi-Cal recipients in need of diagnostic and treatment services were referred to the state Medicaid program. The details of the treatment package were not itemized.

Provision for Annual Assessment. All states except Mississippi mentioned provision for periodic assessment, although the definition of this term differed greatly. Several states called for annual assessments regardless of age (New Jersey, Missouri, and

Illinois). Tennessee, Oregon, California and Massachusetts developed a visit schedule by age of intervals when a child should be screened. As another example, Massachusetts provided for visits at 2-6 weeks, 8-10 weeks, 4 months, 6 months, 9 months, 1 year, 1 1/2 years, yearly 2-6, at 8 years and 10 years. Ohio authorized screening at ages 1, 4, 7, and 16. Texas provided for annual assessment for children under six and every three years from 6-21. Mississippi did not specify a plan for periodic assessment.

Mental Health Consultation. Although many of the states mentioned the importance of uncovering physical and mental defects the availability of mental health consultation was limited. Oregon is the only state which made provision for mental health referral/treatment and prior authorization was needed before treatment could begin. California provided for referral for "mental health conditions" (such as mental retardation) uncovered in screening. Illinois provided space for mental development assessment on the billing form; however, the manual text did not detail the provision of such services. Moreover, it seemed likely that this service could be interpreted as a developmental assessment. Mississippi mentioned that mental health facilities were available for neurological/developmental referrals. Montana provided for psychological testing if indicated. All of the states made provision for developmental assessments. Texas, Oregon, California, and Montana all recommended that the Denver Developmental Screening test be the instrument for evaluating the children.

C. STATE MEDICAID/EPSDT PLAN PROFILE FOR TARGET STATES

Analysis of Findings

The management of the EPSDT program can be divided into four central functions: administration, health services, support services, and fiscal matters. Responsibility for these four areas was so distributed that no state public welfare agency retained total management. In Ohio and Missouri, the state welfare agency retained three of four functions, and only partially delegated the management of supportive services. On the other hand, the state public welfare agency in Illinois partially delegated all functions except fiscal, while the Massachusetts agency retained administration but partially delegated all others. The health function was most frequently "totally delegated"--eight out of 12 state public welfare agencies reviewed. This pattern is understandable since the management of the health function requires special expertise in health service delivery, and fiscal intermediaries such as Blue Cross and Blue Shield were used.

The function most frequently retained by the state public welfare agency was fiscal management; five out of 12 state welfare agencies retained this function. Administration and support services were partially delegated to a greater extent than other functions: seven out of 12 state agencies.

The diffusion of responsibility for managing various EPSDT functions is not surprising given the history of the implementation of Title XIX among the states. There has been a marked tendency for health-related functions to be performed by public health rather than welfare agencies; many public welfare agencies have retained responsibility for fiscal management because of Title XIX requirements, but shared the operation of other administrative and support services. Even though the fiscal function was most often cited as being retained, it was actually retained with relatively low frequency.* This delegation of functions often underlies difficulties in coordination and poses problems to external entities such as Head Start which attempt to gain access to or influence the system.

SRS permits the states to define eligibility for Medicaid in terms of either persons who are defined as categorically needy only (receiving financial assistance paid for in part by federal funds) or those who are categorically and medically needy (which may include persons with special assistance needs for health services because of lower income or requirements for extensive health care). Analysis of the states' EPSDT plans indicated that six states--New Jersey, Mississippi, Ohio, Texas, Missouri, and Oregon--provided Medicaid, and therefore EPSDT services, only for those persons who are categorically needy. Massachusetts, Maryland, Tennessee, Illinois, Montana, and California, on the other hand, have more liberal eligibility criteria for Medicaid and include the medically needy. Information obtained in the on-site visits indicated that these differences have an important bearing.

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*A detailed study of the impact of delegating fiscal management at the national level might prove very important.

It has been impossible, to date, to pinpoint the frequency with which each state required redetermination of Medicaid eligibility. Redetermination is defined as personal interaction of the client with the responsible public agency including presentation of supporting documentation required to continue Medicaid eligibility as opposed to internal review of status, etc., by the agency. According to available information, five states specify that eligibility determination is to be done at six-month intervals.

SRS regulations direct that the state EPSDT agency use as many different types of providers as possible to implement the EPSDT program. SRS also encourages efforts to provide vendor status for these various community providers, thereby ensuring reimbursement for their services. The state Medicaid plans were reviewed to determine the types of providers deemed eligible for vendor status for the overall medicaid program. The categories analyzed included public health agencies, hospitals, private voluntary clinics, private physicians/dentists, community agencies, and other health practitioners (optometrists, physical and rehabilitative therapists, etc.). Four target states, Illinois, Ohio, California, and Oregon, allowed for all six kinds of providers for their Medicaid programs; six states excluded only community agencies as eligible vendors.

All of the target states deemed hospitals, private physicians/dentists, and other health practitioners to be eligible vendors. The provisions for eligibility of other health practitioners varied extensively, with categories such as chiropractors and optometrists being frequently included. California includes a number of the more recently recognized health practitioners within its definitions of eligible vendors. All states except Missouri include public health agencies, and Tennessee was the only state to include private voluntary clinics.

In general, most, if not all, state EPSDT plans provided for traditional providers of medical and health services to be eligible vendors. Only 50% of the states deemed community agencies eligible vendors for the Medicaid program. Such exclusion could potentially have the adverse effects of limiting the EPSDT agency's information, outreach, and screening programs and of impeding Head Start efforts to obtain reimbursement for services it can provide more effectively. Joint vendor status, as provided by Missouri, might be a helpful alternative; a community agency can thus be a vendor in concert with a more traditional provider. The Springfield project is scheduled to become a vendor under this provision in concert with a local, and supportive, physician.

The state plans were also reviewed to determine their level of specificity. It should again be noted that the plan in this regard includes additional information as provided in the state Title XIX plan or telephone contact. Seven out of the 12 state plans were detailed; four provided only general information; and one had no plan to speak of (although some operational aspects were presented in other documents). The level of detail generally correlated specific functions and subordinate activities with the extent to which responsibility was retained. For example, supportive services tended to be least specific, and eligibility determination, an activity for which the public welfare agencies retained responsibility, also was not generally detailed.

D. STATE/LOCAL EPSDT ORGANIZATIONAL RESPONSIBILITY IN TARGET STATES

Analysis of Findings

Comments and insights solicited from selected Head Start projects, public agencies, and community agencies including providers of service helped broaden the picture of the organizational and operational aspects of the EPSDT system. These sources were complemented by materials pertaining to EPSDT that had been distributed by state and local agencies and were collected and reviewed. Since much information is still in the process of being gathered this analysis should be considered preliminary.

Organizational responsibility for EPSDT functions is described at two levels of administration:*

- interagency relationships at the state level
- state and local governmental agency relationships.

The extent of actual delegation of responsibility by the state public welfare agency to another governmental unit is more likely to cause confusion than the administrative mechanisms described in the state plan. It should be noted that in two instances, Mississippi and California, separate state agencies have been delegated almost complete authority for Medicaid/EPSDT. In Mississippi the responsibility was transferred to the Mississippi Medicaid Commission and in California new organizational entities--Child Health Disability Prevention Programs--are being established on the local level. Also of interest is New Jersey which has established interagency relationships among four different health and welfare units as well as a private insurance carrier.

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*See Table XII in the Final Report for greater detail.

The relationship at the state interagency level was defined through a contractual agreement in 14 instances. Only one state, Massachusetts, had an informal agreement at this level--in this instance between the public welfare and health agency. In New Jersey, the different state level agencies involved in EPSDT were structured so that they were ultimately responsible to the state public welfare agency, but functioned as semi-autonomous units.

In reviewing the target states we found the most frequently cited* parties to interagency relationships to be the public welfare and public health agencies (eight out of 12 states). The second most frequently cited interagency relationship involved the public welfare agency and a private insurance carrier. The frequency of welfare and health agency involvement is to be expected because of the requirements of Medicaid/EPSDT; interestingly, at least 50% of the target states contracted with a non-governmental entity namely, a private insurance carrier such as Blue Cross, to be responsible for the fiscal management of EPSDT.

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*It is assumed that the public welfare agency is a party to the contract even where it is not specifically cited because of Title XIX requirements.

The public welfare agency was most frequently cited (ten out of 28 times) as having organizational responsibility for specific EPSDT functions. The next most frequently cited agency was the public health agency, eight out of 28 times.

Since welfare agencies rarely have the resources to provide comprehensive health services, it is necessary for them to contract for the provision of such services. The medical function was most frequently accomplished through an interagency agreement, 13 times as compared to once for transportation. The states usually chose health-type units to be responsible for the medical function, e.g., public health department, state health agency, or a medical assistance unit. In some instances, e.g., Texas, the health department directly provides EPSDT services while in other states, public health agencies have th responsibility for finding providers and arranging for screening rather than directly providing such services.

Ten out of 22 state and local governmental agency relationships involved the local welfare board. In seven states, however, the local board was a decentralized unit of the state public welfare agency. In such states, the local welfare board has considerable autonomy, and policies and procedures may vary from locality to locality with consequent confusion for agencies and individuals having to interact with them.

In New Jersey, the greatest proliferation of units had organizational responsibility for different EPSDT functions. An additional complication in New Jersey is that while local agencies determine eligibility, the units responsible for locating providers are administered statewide.

The fact that EPSDT was primarily maintained as a state administered program is reflected in the relationships between state and local agencies. Thirteen out of 22 such relationships involved an organizational unit that was part of the state administrative system. In six instances, the unit was under local authority, and the number of contracts needed and used to define the relationship between state and local units was drastically reduced.

Again, as in the case of state interagency relationships, the medical function was found to be most frequently delegated between state and local agencies--12 out of 22 delegations of this nature existed. Health agencies were the primary actor at the local level.

Local units were largely responsible for follow-up and recordkeeping, transportation, notification of eligibles, and public information. For instance, follow-up and recordkeeping were delegated 11 times. At the state level, in contrast, there was only one interagency agreement established for this purpose. In many cases, the actual collection of health service records was performed by the local agency, but the data was maintained at both local and state levels for reporting to SRS. There is a similar shift of responsibility in the case of transportation services, ten such delegations to the local level and one state interagency agreement to provide for transportation. Overall, the local welfare board is more frequently responsible for these non-health functions than any other local unit.

E. PROVIDER PROVISIONS AND ATTITUDES BY SELECTED PROJECTS

An important issue for the implementation of the EPSDT program is the extent to which providers of EPSDT services, including Head Start agencies, can achieve vendor status. The Eugene project--the only project to achieve vendor status--has used the newly freed money to establish a dental clinic and expand outreach.

Nine target states placed restrictions on the vendor status of providers of Medicaid services, Oregon, Ohio, and California being the exceptions. There were proportionately fewer restrictions on providers/vendors treating EPSDT children. Only Mississippi restricts treatment vendors while Mississippi, Tennessee, Illinois, and Texas restrict vendors of screening services. Maryland placed no legal restrictions on vendors screening EPSDT children. Unfortunately, the EPSDT paperwork was often so consuming or merely duplicative that physicians sometimes chose not to complete the forms. Or, as in Illinois, physicians not only found the forms unacceptable, but they also objected to the bureaucratization of governmentally funded medical services. Therefore, the problems of vendor/provider restrictions are intensified by the attitudes of the particular physicians.

Although only three states required that providers complete an EPSDT participation agreement to screen or treat eligible children, a number of states have provided for accountability measures with regard to reimbursement procedures. Eleven states stipulated separate billing on reporting forms for EPSDT. The rate system for reimbursement allowed for much flexibility with only Massachusetts setting a fixed fee for general Medicaid services and with four target states permitting physicians to charge their customary fee. Various states made special provisions for EPSDT screening with only Missouri setting no special fee for this service.

Within the health service network, relatively few states used public providers. Those that did found them generally positive. The projects virtually all used private providers, and found them, on the whole, negative in their attitude toward EPSDT. Although the private providers were cooperative, they objected to EPSDT for such reasons as unacceptable rates, inordinately cumbersome paperwork, disagreement with state policy, and snags in the repayment process.

F. SELECTED PROJECTS' RELATIONS WITH STATE AND LOCAL MEDICAID/EPSDT AGENCIES

The guidelines for Head Start/EPSDT specify that Head Start establish relationships with state and local Medicaid/EPSDT agencies toward the implementation of the demonstration effort. Such relationships were frequently initiated with local agencies (88% of the selected projects) and were less frequently initiated with the state unit responsible for the Medicaid/EPSDT program (48%). For the most part, Head Start was responsible for the contacts, although the state Health Liason Specialist assumed the active role in some instances.

The tendency to establish relationships with the local offices rather than the state agencies is explicable by the very nature of the collaborative effort. To effectively administer the collaborative effort, Head Start would require close working arrangements with those agencies which would most readily provide such essentials as direct health services and follow-up support. Although the formal agreement had been with the state office, frequent decentralization rendered the local offices more helpful. Further, operational cooperation proved a more realistic and expeditious goal than institutional change at the state level, given the politics of higher level decision making.

Within the resulting agency network, it is understandable that the relationship between the local Medicaid/EPSDT agency and Head Start project was informal and usually verbal. Only Eugene, Oregon had a written agreement with the agency, and that agreement had been in effect prior to the collaborative effort. The Head Start-agency relationships ranged from being minimally communicative to fairly constructive, for example, resulting in an increase in follow-up services and in easier availability of lists of Medicaid eligible children and of providers and vendors.

G. TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE FOR THE SELECTED PROJECTS

What technical assistance was provided came most often from the Health Liaison Specialist and less frequently from the state Medicaid/EPSDT agency, although that agency was the most helpful of governmental sources. Most of the projects cited lack of technical assistance as one of the chief detriments to the success of the collaborative effort. The Toms River project had not, in fact, received assistance from any source.

Most often the technical assistance consisted of workshops and information provision. There was some help in improving relationships with local EPSDT agencies, but only six of the 25 projects received actual supportive services aid. Even more telling is that no project received technical assistance in fiscal management, perhaps accounting for the lack of monetary reimbursement to any of the demonstration projects.

Although the Health Liaison Specialist was singled out as most helpful, on-site visits revealed a greater need for the specialist to be physically present at the projects and for the proferred assistance to be more constructive than the usual information provision. Perhaps fear of criticizing the specialist relegated this contradiction regarding the effectiveness of assistance to mere inference.

On the state level, although most plans call for EPSDT agency assistance in such areas as outreach, supportive services, and enhancement of provider capacity to deliver hard services, the technical assistance actually received was negligible. Major assistance is needed in the areas of workshops and information, planning and administration, and supportive services.

VIII. COST REVENUE IMPACT OF THE HEAD START/EPSDT COLLABORATIVE EFFORT

Introduction

A major task for the evaluation of the Head Start/EPSDT Collaborative Effort was to assess the cost impact of the program on the participating demonstration projects. Attention was also to be given to the quantifiable outcomes of the collaboration regarding reimbursement revenues and the particular revenue sources obtained by the various projects to support the effort, as well as the assessed value of services received by the participating groups (selected projects only). The following tables, therefore, analyze information germane to the cost/revenue aspects of the demonstration program:

- Table XVII - Revenue Sources Used to Support the Head Start/EPSDT Collaborative Effort
- Table XVIII - Head Start/EPSDT Expenditures by Source
- Table XIX - Head Start/EPSDT Expenditures Re: Direct, Supportive and Administrative Costs; Cost Per Child
- Table XX - Medicaid Involvement in the Payment of EPSDT Services for Medicaid Certified Participants.

The instruments used to collect data presented in the above tables were the Head Start/EPSDT Income Sources Form, the Head Start EPSDT Expenditure Form, and the Health Care Encounter Form.

The response rate of the demonstration projects to the aforementioned instruments was relatively low. As of this report, a total of 46 (23%) of the 198 participating projects submitted the Income Sources Form. Eight of these projects were selected projects. Even fewer projects responded to the Expenditure Form. Only 45 projects (21%) of all the projects forwarded information via this instrument. Of these projects, five were selected projects.

Repeated efforts were made during the course of the evaluation to obtain the requisite information. In each instance, those projects not responding were contacted and requested/encouraged to complete and return the forms as soon as possible. The projects were advised of the importance of their response relative to the validity of the evaluation study. These efforts, however, had no material impact on the response rate. It should be noted that completion of these forms came at the end of the year. It was, therefore not possible to persist in seeking this information since many projects were closed, and staff was not available.

The primary reason for the low response rate may have been the lack of cooperation the health coordinators received from the fiscal officer* of the program. Without assistance from this staff person, many health coordinators felt at a loss to attempt completion of the forms themselves. Moreover, many projects did not understand the information being requested and failed to inquire. Nonetheless, because of the low response rate to both forms, any definitive statements made regarding the data tables are only relative to the universe of projects reporting. Speculation as to the revenue/cost impact of the collaborative effort can only be advanced concerning the balance of projects not reporting.

It should further be noted that the information reported by these projects was not subject to audit and, therefore, was taken at face value.

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*This individual was designated responsibility to assist the health coordinator in completing the Income Sources Form and the Expenditure Form.

A. REVENUE SOURCES OBTAINED BY THE DEMONSTRATION PROJECTS TO SUPPORT THE COLLABORATIVE EFFORT

A profile of revenue sources obtained by the various demonstration projects to support the Head Start/EPSDT Effort is provided in Table XVII. Information was taken from the Income Sources Form and arrayed by region, state, and program to indicate the extent to which each region, state and program made maximum use of all available resources regarding the implementation of Head Start/EPSDT.

This table outlines six possible sources of revenue that may have been used by the demonstration projects in support of the collaborative effort. These are:

- Governmental - amount of monies received/earned through federal, state and local grants in connection with the Head Start/EPSDT Collatorative Effort.
- Third Party Payors - amount of monies received/earned through third-party payors such as Medicaid (Title XIX) and other purchase of service agreements that have been reached.
- Direct Patient Payments - amount of dollars received/earned through direct payments made by families on behalf of children participating in the collaborative effort.

- Cash Contribution - amount of unearned income from voluntary contributions, e.g., foundations, endowments, etc.

- Donated Services and Materials - the assessed value of in-kind support from non-cash donations, e.g., volunteer personnel services, materials and other contributions of a non-cash nature which are incremental to program services

- Other Revenue - amount of any other revenue from income--earning efforts such as sales, interest, etc.--not previously listed.

As a point of reference, none of the 198 demonstration projects participating in the Head Start/EPSDT Collaborative Evaluation (with the exception of Eugene, Oregon) had reached agreements with state/local Medicaid agencies for direct third-party reimbursement. This, however, was not a priority objective of the first year effort. It is anticipated that the second year evaluation will place more emphasis on the demonstration projects securing direct third party monies through purchase of service agreements with state/local agencies. Thus, monies shown in Table XVII as Title XIX/Medicaid did not constitute vendor status* on behalf of the project. Rather, data from this table represented the projects' estimate of Title XIX monies obtained by health providers for services rendered to Medicaid eligible children (of the respective projects) participating in the collaborative effort.

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*Vendor status - recognized as a provider of health services (for which Title XIX monies can be received) by the state/local Medicaid agency.

1. Analysis of Findings

Table XVII shows that an overwhelming majority of the demonstration projects reporting were very much dependent upon the supplemental grant provided by the federal government for support of the Head Start/EPSDT effort. Project grants ranged from $500 to $16,500 as reported by Jackson County Child Development Centers of Medford, Oregon and Prairie Opportunity, Inc. of Starkville, Mississippi respectively. Monies generated through other sources were minimal by comparison and in some categories no monies were reported at all.

It appears that there was no direct relationship between the number of children enrolled and/or participating in the Head Start/ EPSDT Collaboration, by project, and the amount of monies allocated by project, for the implementation of the collaborative effort. For example, the South Middlesex Opportunity Council of Farmingham, Massachusetts indicated it planned to serve 250 children for which it received $10,000 in supplemental monies. In contrast, the Paterson Task Force for Community Action of Paterson, New Jersey only received $8,000 from the federal government with a planned population of over 5,000 to be served. Thus the rationale for the distribution of supplemental funds was not clearly discernible.

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Payment	Found-ations	Endowments	Private	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION I													
Massachusetts:													
Framingham	$10,000			$ 9,500						$12,000	$ 1,000		$32,000
•Gloucester	10,000												10,000
Turner Falls	10,200		$ 400	16,974	$ 1,561					925	15	$ 62	30,137
•Pittsfield	10,000												10,000
Danielson	10,000										110	16	10,126
Total	$50,200		$ 400	$26,474	$ 1,561					$12,925	$ 1,125	$ 78	$92,763
Vermont:													
Newport	$10,000			$ 114						$ 585			$10,699
•Winooski	10,000												10,000
Total	$20,000			$ 114						$ 585			$20,699
Connecticut:													
Jewett City	$10,000									$ 4,000			$14,000
Regional Totals	$80,200		$ 400	$26,588	$ 1,561					$17,510	$ 1,125	$ 78	$127,462
REGION II													
New York:													
Watertown	$ 8,000									$ 1,237			$ 9,237

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Foundations	Endowments	Private Contributions	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION II (CON'T)													
New Jersey:													
*Orange	8,000												8,000
Toms River	20,005	$ 2,906	$ 1,487		$ 2,000								26,398
Paterson	8,000											$ 2,296	10,296
Total	$36,005	$ 2,906	$ 1,487		$ 2,000					$ 1,237		$ 2,296	$44,694
Regional Totals	$44,005	$ 2,906	$ 1,487		$ 2,000					$ 1,237		$ 2,296	$53,931
REGION III													
Maryland:													
Salisburg				$ 550						$ 200	$ 25		$ 775
Regional Totals				$ 550						$ 200	$ 25		$ 775
REGION IV													
Mississippi:													
Starkeville	$16,500			$3,800						$2,200		$ 250	$22,750
Yazoo	5,649			191	$3,380								9,220
Total	$22,149			$3,991	$3,380					$2,200		$ 250	$31,970

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Foundations	Endowments	Private Contributions	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION IV (CON'T)													
Tennessee:													
Kingston	$10,000			$ 1,949	$ 150	$ 530				$ 280			$12,909
Alabama:													
• Anniston	$10,000												$10,000
Georgia:													
Monticello	$10,000								$ 25				$10,025
Gainesville	10,000									1,750	50	200	12,000
Total	$20,000								$ 25	$ 1,750	$ 50	$ 200	$22,025
Kentucky:													
Frankfort	$16,000									$ 4,000			$20,000
Regional Totals	$76,149			$ 5,940	$ 3,530	$ 530			$ 25	$ 8,230	$ 50	$ 450	$96,904
REGION V.													
Illinois													
Cook County	$15,000									$ 200	$ 300		$15,500
Waukegan	10,000									6,000	100	2,811	18,911
Total	$25,000									$ 6,200	$ 400	$2,811	$34,411

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Foundations	Endowments	Private Contributions	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION V (CON'T)													
Wisconsin													
• Wisconsin Rapids	$ 5,000												$ 5,000
• Superior	10,000												10,000
Total	$15,000												$15,000
Regional Totals	$40,000									$ 6,200	$ 400	$ 2,811	$49,411
REGION VI.													
Texas:													
Wichita Falls	$ 5,000			$ 3,494	$ 404					$ 98			$ 8,996
• San Antonio	5,000												$ 5,000
Amarillo	10,000										50		10,050
Total	$20,000			$ 3,494	$ 404					$ 98	$ 50		$24,046
Arkansas:													
• Hot Springs	$ 5,000												$ 5,000
Oklahoma:													
Chickasha	$ 5,000									$ 1,000	$ 200	$ 1,900	$ 8,100
Regional Totals	$30,000			$ 3,494	$ 404					$ 1,098	$ 250	$ 1,900	$37,146

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Foundations	Endowments	Private Contributions	Donated Services	Donated Materials	Other	Total All Revenue Sources
REGION VII.													
Missouri:													
Joplin	$ 5,000									$ 1,100	$ 35	$ 40	$ 6,175
Kirkville	5,000			525									5,525
Total	$10,000			$ 525						$ 1,100	$ 35	$ 40	$11,700
Kansas:													
Horton	$ 5,000												$ 5,000
Girard	5,000			4,502							75	750	$10,327
Total	$10,000			$ 4,502							$ 75	$ 750	$15,327
Regional Totals	$20,000			$ 5,027						$ 1,100	$ 110	$ 790	$27,027
REGION VIII.													
Colorado:													
Pueblo	$ 3,900				$10,000							$ 250	$14,150
Trinidad	5,000			642							481		6,123
Total	$ 8,900			$ 642	$10,000						$ 481	$ 250	$20,273
Utah:													
Salt Lake City	$50,920									$ 8,000	$ 100		$59,020
Regional Totals	$59,820			$ 642	$10,000					$ 8,000	$ 581	$ 250	$79,293

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Found-ations	Endowments	Private Contribu-tions	Donated Services	Donated Materials	Other	Total All Revenue Sources
IMPD PROGRAMS													
Montana:													
Blackfeet	$ 3,400												$ 3,400
Flathead	8,498			840	1,230					584			11,152
Fort Peck	6,600			2,340									8,940
Total	$ 13,498			$ 3,180	$1,230					$ 584			$ 23,492
Nesbraska:													
Santee Sioux IMPD Totals	$ 5,900												$ 5,900
Regional Totals	$ 24,398			$ 3,180	$ 1,230					$ 584			$ 29,392
SUMMARY TOTALS	$ 431,798	$ 6,886	$ 1,887	$61,925	$18,725	$ 530	-0-	-0-	$ 25	$47,370	$ 7,724	$ 9,318	$586,188

REVENUE SOURCES USED TO SUPPORT THE HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVII (Cont'd)

Projects By Region/State	Federal	State	Local	Title XIX	Other Third Party	Direct Patient Payments	Found-ations	Endowments	Private Contribu-tions	Donated Services
REGION IX.										
Hawaii:										
Kauai	$ 8,979	$ 3,980								
Regional Totals	$ 8,979	$ 3,980								
REGION X.										
Oregon:										
Scappoose	$13,331			$ 1,612						150
La Grande	14,586									221
Medford	500			13,000 Est.						$ 2,840
* Salem	5,700									
Roseburg	12,130			1,892						
Total	$46,247			$16,504						$ 3,211
Regional Totals	$46,247			$16,504						$ 3,211

A total of $586,188 was obtained/generated for the collaborative effort among the 46 projects reporting. Exhibit V illustrates the percentage distribution of this amount between the respective revenue categories. The distribution shows that federal funds (supplemental grant) of $431,798 far out-distanced the other categories as the major contributor to the Head Start/EPSDT effort and accounted for 73.7% of all monies generated. In addition, monies generated through Medicaid/Title XIX ($61,925/10.6% of total) and Donated Services and materials ($55,094/9.4% of total) combined to represent 20% of the total funds available to support the collaborative effort. These categories, together, became the second largest supporter of the collaboration. Exhibit V also indicates that very few dollars were provided through state and local governments, cash contributions, etc.

The data supports, as previously indicated, a strong reliability on the supplemental grant for maintenance of the demonstration program. Table XVII shows that eleven (24%) of the 46 projects reporting rely solely on supplemental grant dollars for support. These programs are identified in the table by an asterisk (*) placed next to their names. Analysis also reveals a modest dependence on Donated Services and Materials. It is interesting to note that five projects indicated financial support in this area ranging from 20% to 36% of the total of all monies received. Reference Exhibit VI.

EXHIBIT V

PERCENTAGE ALLOCATION OF MONIES RECEIVED IN SUPPORT OF COLLABORATIVE EFFORT

CATEGORY	AMOUNT	%
Federal Government	$ 431,798	73.7
State Government	6,886	1.2
Local Government	1,887	.3
Medicaid (Title XIX)	61,925	10.6
* Other	18,725	3.2
Direct Patient Payments	530	.1
Cash Contributions:		
Foundations	-0-	-
Endowments	-0-	-
Private	25	-
Donated Services and Materials:		
Services	43,370	8.1
Materials	7,724	1.3
** Other	9,318	1.5
Totals	$ 586,188	100.0%

* Other monies obtained through third party sources.

** Other income earning efforts in support of the collaborative effort such as sales, interest, etc. not previously recorded.

EXHIBIT VI

COMPARISON OF FINANCIAL SUPPORT

Head Start/EPSDT Project	Total All Monies Received In Support of Effort	Total Monies Received-Donated Services & Materials	Percentage Relationship
South Middlesex Opportunity Council Framingham, Massachusetts	32,500	12,000	36%
Thames Valley Council Jewitt City, Connecticut	14,000	4,000	28%
Kentucky Youth Research Frankfort, Kentucky	20,000	4,000	20%
Lake County C.A.P. Waukegan, Illinois	18,911	6,000	31%
Parent Action Council Roseburg, Oregon	19,170	5,148	26%

Most other projects, as Table XVII shows, reported revenues from Donated Services and Materials. These amounts, however, were not significantly large and would not greatly impact on support of the collaborative effort.

What is obvious from the data is that few projects had financial commitments from sources other than the federal, state, and local governments. Contributions from the private sector (foundations, endowments, individuals, etc.) were simply non-existent. This, however, is not surprising as most programs were not engaged in a community-wide effort to solicit money from private sources to support the Head Start/EPSDT program. This was also not a priority objective of the program.

Region I reported receiving $127,462 in support of the collaborative effort. This was the highest amount reported among the regions and IMPD programs. The best return rate of the Revenue Sources Form was also experienced in this region with 50% (10 out of 20) of the programs submitting the requisite information. This, of course, contributes significantly toward the amount indicated and suggests that other regions may have fared as well or better depending upon their response rates. Region III, on the other hand, reported obtaining $775--the least among the regions and IMPD programs. The response rate in this region was very poor with only one of the ten affiliate projects reporting. Again, the poor response rate is directly attributable to the minimal amount reported. The variations in responses among the regions, therefore, preclude making objective comparisons regarding the amount of monies received.

2. Conclusions on Revenue Sources Obtained to Support the Collaborative Effort

a. Supplemental grants received by the demonstration projects varied widely. There was no apparent correlation between project size (number of children to be served) and the amount of monies allocated per project for implementation of the collaborative effort.

b. To a very large extent, most of the demonstration projects depend upon the supplemental grant for support of the effort. For every dollar generated in support of the effort, the supplemental grant represented approximatley 74 cents. It is further concluded that the collaborative effort could suffer greatly, if the supplemental grants were discontinued as most programs show no immediate alternative method of financing.

c. Despite the reliance by the demonstration projects on the supplemental grant, some projects showed initiative in generating dollars through Medicaid/Title XIX and Donated Services and Materials. These categories accounted for 20 cents of every dollar spent by the projects on the Head Start/EPSDT Collaborative Effort.

d. Monies generated outside the government agencies were of very little consequence.

e. It can be speculated that if information were available on the balance of projects not reporting, it would have little influence on the above conclusions reached, particularly regarding the distribution of the supplemental grant monies and dependence on same for support of the collaborative effort.

3. Policy Considerations on Revenue Sources Obtained to Support The Collaborative Effort

a. If the supplemental grant is to continue, it is suggested that monies could be distributed based on a formula that reflects program size and other variables. This could greatly contribute to an equitable means of allocating supplemental monies among the programs.

b. Programs could be encouraged to begin soliciting sources other than the supplemental grant for support of the collaborative effort. Suggestions are:

  - recognition as a provider of health services by the local/state Medicaid agency, whereby third party monies accrue directly to the demonstration project. These monies can then be reprogrammed or earmarked for subsequent EPSDT health and support related services.

  - where provider recognition is not possible, programs may be encouraged to reach agreements with local health providers (which are recipients of third party revenues) to share in any monies they receive as a result of services rendered to children of the local projects. As in the above situation, these monies can be used for future EPSDT services

  - implementation of direct patient payments (for non-Medicaid eligible families only) predicated on a sliding fee scale system which takes into account the family's ability to pay

  - solicitation at the local community level to attract monies from the private sector, e.g., sponsorships, contributions, loans, etc.

B. SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT (TABLES XVIII AND XIX)

The expenditure form was used to collect information on the amount of monies expended by the demonstration projects in support of the collaboration effort. The form was also designed to assess the per child cost of screening and treatment and related supportive and administrative services. Information reported was for the period July 1, 1974, to June 30, 1975.

There was wide disparity in reporting among the demonstration projects regarding the expenditure form as compared to its counterpart--the income form. It appears that most projects did not understand that the amount of monies reported as available for the collaborative effort (reference Table XVII) was directly related to the amount of monies that could be expended on the effort. In fact, many projects reported more monies expended than were actually available.

Because of the lack of data and, in some instances, its unreliability, it was not possible to undertake the kind of analysis anticipated. Therefore, no conclusions can be drawn relative to the cost impact of the Head Start/EPSDT Collaborative Effort for the universe of 198 projects. However, for those projects reporting, the available data on the dispersion of these costs are summarized in Tables XVIII and XIX. Conclusions and recommendations as to the findings also follow, but are limited to the universe of projects reporting.

Information by region, state and project concerning the source of expenditure for the collaborative effort, e.g., Head Start/ EPSDT (supplemental grant), cash contributions, in-kind contribution, etc., is presented in Table XVIII. The table further summarizes the total amount of expenditure from all sources for each region, state and project.

Monies expended by the demonstration projects on the collaborative effort (including EPSDT payments to providers, as estimated by the projects) are categorized into three major groupings in Table XIX:

- Direct Costs
- Supportive Cost
- Administrative Costs

This table further provides the per child cost of EPSDT services, by dividing the universe of children served into the total cost of all services rendered.

Definition of Terms

Direct Costs refers to those costs which are directly attributable to services rendered to children and their families participating in the Head Start/EPSDT program, e.g., wages paid to staff personnel directly involved in administering medical services, cost of supplies (prostheties, pharmaceuticals, etc.) used in the course of rendering health services, etc.

Supportive Costs refers to those costs which are necessary to ensure quality and ongoing services to children and their families, e.g., wages paid to staff persons who are not directly involved in EPSDT medical treatment, but who perform functions which induce better or continuing patient services, such as outreach, EPSDT staff training, etc. The cost of providing transportation to and from the clinic setting would also be germane to this category.

Administrative Costs refers to those costs which support overall Head Start/EPSDT operations, but which are not associated with direct medical services to the collaboration participants, e.g., wages paid to Head Start/EPSDT administrative staff, cost of transportation, materials, etc., which are attribritable to EPSDT administrative functions.

1. Analysis of Findings (Table XVIII)

Projects reported that they spent a total of $656,383 on the collaborative effort. As expected, the majority of these monies, $496,087 (76%), came from the Head Start/EPSDT supplemental grant. Other federal dollars in the amount of $68,591* paid for 10% of health and related EPSDT services provided to children, thus representing the second largest expenditure source in support of the collaboration. Contributions from other sources were significantly less. Exhibit VII provides data on the amount of contribution by expenditure source and its distribution as a percentage of the total.

Interestingly, EPSDT Medicaid was rarely a source of funds used regarding health services to all Head Start/EPSDT participants. Figures show that only 6%, $41,858, was used for health and related services from this source. This may have been a result of under-reporting by the projects. However, Medicaid's participation as a funding source increases relative to Medicaid payments for services rendered to Medicaid certified children--both Head Start and non-Head Start. This will be explained in next section. For example, projects reported

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*This amount appears unusually high and may be the result of misinterpretation. That is, some programs may have inadvertently reported expenditures from the supplemental grant under the "Federal" category as opposed to the "Head Start/EPSDT" expenditure category.

EXHIBIT VII

SOURCE OF EXPENDITURES FOR HEAD START/ EPSDT COLLABORATIVE EFFORT

Expenditure Source	Amount	Contribution By Source
Head Start/EPSDT	$496,087	76%
Non-Cash In-Kind Contributions	32,062	5%
Cash Contributions	69	-
Federal (Other than Supplemental Grant	68,591	10%
State	5,743	1%
Local	4,529	1%
EPSDT/Medicaid	41,858	6%
Other	7,445	1%
TOTAL	$656,384	100%

NOTE: Information is based on a total of 45 projects reporting, which represents 23% of the 198 projects participating in the Collaborative Effort.

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII

Projects by Region/State	Head Start/ EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION I									
Massachusetts: Gloucester	$ 11,325								$ 11,325
Pittsfield	19,322		$ 40						19,362
Greenfield	2,046	$ 319				$ 190	$ 1,131	$ 60	$ 3,746
Total	$ 32,693	$ 319	$ 40			$ 190	$ 1,131	$ 60	$ 34,433
Vermont: Newport	$ 10,150								$ 10,150
Winooski	10,000								10,000
Total	$ 20,150								$ 20,150
Connecticut: Danielson	$ 9,684	$ 141		$ 13,661			$ 2,146		$ 25,632
Jewett City	9,886	$ 4,000							$ 13,886
Total	$ 19,570	4,141		$ 13,661		$ 190	$ 2,146		$ 39,518
Regional Totals	$ 72,413	$ 4,460	$ 40	$ 13,661		$ 190	$ 3,277	$ 60	$ 94,101
REGION II									
New York: Watertown	$ 8,102	$ 1,135							$ 9,237

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION II (CONT)									
New Jersey: Orange	$ 5,278								$ 5,278
Regional Totals	$13,380	$ 1,135							$14,515
REGION III									
Maryland: Salisbury	$10,000	$ 225					$ 550		$10,775
West Virginia: Roanoke	$ 5,567								$ 5,567
Regional Totals	$15,567	$ 225					$ 550		$16,342
REGION IV									
Mississippi: Starkeville	$ 8,240						$ 3,800		$12,040
Yazoo	12,300			$ 5,649	$ 3,380		191		21,520
Total	$20,540			$ 5,649	$ 3,380		$ 3,991		$33,560
169 Tennessee: Kingston	$ 6,866	$ 24	$ 4		$ 334	$ 120	$ 715		$ 8,063
Alabama Anniston	$ 7,976								$ 7,976

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SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION IV (CONT.)									
Georgia:									
Monticello	$ 10,252	$ 489	$ 25	$ 1,513		$ 640	$ 320		$ 13,239
Gainesville	13,000	300							13,300
Total	$ 23,252	$ 789	$ 25	$ 1,513		$ 640	$ 320		$ 26,539
Kentucky:									
Frankfort	$ 16,000	$ 4,000							$ 20,000
Regional Totals	$ 74,634	$ 4,813	$ 29	$ 7,162	$ 3,714	$ 760	$ 5,026		$ 96,138
REGION V									
Illinois:									
Cook County	$ 30,016	$ 3,173		$ 3,254		$2,746	$22,230		$ 61,419
Waukegan	15,035	6,100						$ 2,811	23,946
Total	$ 45,051	$ 9,273		$ 3,254		$2,746	$22,230	$ 2,811	$ 85,365
Wisconsin:									
Wisconsin Rpds.	$ 5,000								$ 5,000
Superior	5,503								5,503
Total	$ 10,503								$ 10,503
Regional Totals	$ 55,554	$ 9,273		$ 3,254		$2,746	$22.230	$ 2,811	$ 95,868

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION VI									
Texas:									
Witchita Falls	$ 3,951	$ 98				$ 404	$ 3,494		$ 7,947
San Antonio	5,904								5,904
Amarillo	5,000	900		$ 2,653	$ 1,000				9,553
Total	$ 14,855	$ 998		$ 2,653	$ 1,000	$ 404	$ 3,494		$ 23,404
Arkansas:									
Hot Springs	$ 21,909	$ 3,070							$ 24,979
Louisiana:									
Alexandria	$ 9,387			$ 5,000					$ 14,387
New Mexico:									
Carlsbad	$ 6,509	$ 1,995							$ 8,504
Oklahoma:									
Chickasha	$ 37,242								$ 37,242
Regional Totals	$ 89,902	$ 6,063		$ 7,653	$ 1,000	$ 404	$ 3,494		$108,516
REGION VII									
Missouri:									
Joplin	$ 6,175								$ 6,175
Kirkville	5,102						$ 525		5,627

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION VII (CONT.)									
Appleton City	$ 5,000								$ 5,000
Total	$ 16,277						$ 525		$ 16,802
Kansas:									
Horton	$ 5,148								$ 5,148
Girard	42,894	$ 825					$4,502		$ 48,221
Total	$ 48,042	$ 825					$4,502		$ 53,369
Regional Totals	$ 64,319	$ 825					$5,027		$ 70,171
REGION VIII									
Colorado:									
La Junta	$ 4,950	$ 852		$ 4,400		$ 429			$ 10,631
Pueblo	4,825	30		10,000					14,855
Trinidad	5,000	618		3,422			$ 642	$ 1,920	11,602
Total	$ 14,775	$ 1,500		$ 17,822		$ 429	$ 642	$ 1,920	$ 37,088
Regional Totals	$ 14,775	$ 1,500		$ 17,822		$ 429	$ 642	$ 1,920	$ 37,088
REGION IX									
Hawaii:									
Kauai	$ 6,826			$ 9,140	$ 1,029				$ 16,995
Regional Totals	$ 6,826			$ 9,140	$ 1,029				$ 16,995

SOURCE OF EXPENDITURE FOR HEAD START/EPSDT COLLABORATIVE EFFORT

Table XVIII (Cont'd)

Project by Region/State	Head Start EPSDT Expenditures	Non-cash In-kind contributions	Cash contributions	Federal	State	Local	EPSDT Medicaid Title XIX	Other	Total HS/EPSDT Expend. From All Sources
REGION X									
Oregon: La Grande	$ 11,939								$ 11,939
Eugene	43,280	$ 3,350							46,630
Salem	5,700			$ 9,899					15,599
Clatskanie	13,331	418					$ 1,612		15,361
Total	$ 74,250	$ 3,768		$ 9,899			$ 1,612		$ 89,529
Regional Totals	$ 74,250	$ 3,768		$ 9,899			$ 1,612		$ 89,529
IMPD PROGRAMS									
Minnesota: White Earth	$ 45								$ 45
Montana: Flathead	$ 8,498							$ 2,654	$ 11,152
Nebraska: Santee Sioux	$ 5,924								$ 5,924
IMPD Totals	$ 14,467							$ 2,654	$ 17,121
SUMMARY TOTALS	$496,087	$32,062	$ 69	$68,591	$ 5,743	$ 4,529	$41,858	$ 7,445	$656,384

$61,925 in Title XIX monies available for the collaborative effort through revenue sources. It, therefore, seems reasonable that this amount would have been expended. On the other hand, a substantial portion of the various screening tests, usually performed by the health providers, may have been administered by the Head Start/EPSDT staff itself. This would have, of course, precluded Medicaid/EPSDT reimbursements and contributed to a lower percentage of Medicaid/EPSDT expenditures. The lack of Medicaid reimbursements for all EPSDT health and supportive services should also be considered.

As previously indicated, expenditures exceeded the revenue sources available to support the collaborative effort. While this strongly suggests error in reporting, the possibility cannot be dismissed that projects may have reached beyond the revenue sources reported to sustain the implementation of the Head Start/EPSDT program. For example, some projects may have failed to report (in the Income Sources Form) monies spent on the effort which were not specifically earmarked for Head Start/EPSDT, but which were, nonetheless, used for this purpose. This would suggest that in certain cases projects were willing to sacrifice other program objectives or activities to ensure maintenance of the effort. It can be speculated that many of the demonstration projects used monies normally associated with the categorical Head Start grant to meet the financial obligations of the collaboration effort incurred beyond the supplemental grant monies available.

Other analysis shows that Region VI expended $108,515 on the collaborative effort--the most reported among all regions and IMPD programs. Regions I, IV, V, and X all reported EPSDT expenditures in the range of $90,000. Region VII reported somewhat less at $70,171, with Region VIII following at $37,088. Regions III, IX, and the IMPD projects indicated expenditures from $16,000 to $17,000. The least amount reported was in Region II - $14,516. Of course, much of this relates directly to the number of projects reporting. It is, therefore, not clearly discernible whether this trend would have prevailed had the majority of projects reported.

Individually, Cook County of Chicago, Illinois reported spending $16,419 on the collaborative effort. This was highest among the demonstration projects. On the other hand, Nett Lake, Minnesota reported a nominal amount of $45--lowest among all projects.

2. Analysis of Findings (Table XIX)

Table XIX indicates that 48% ($316,399) of all monies spent by the demonstration projects on the collaborative effort was attributable to direct costs. This indicates that nearly fifty cents of every dollar went to salaries of staff directly involved in EPSDT medical services; to the cost of supplies used in the course of providing direct health

HEAD START/EPSDT EXPENDITURES RE: DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS; COST PER CHILD

Table XIX

	Total All Costs	Direct	Supportive	Admin.	No. Of Children Served	Cost Per Child
REGION I						
Mass:						
Gloucester	$11,325.00	$ 9,626.00	$ 1,250.00	$ 449.00	213	$ 53.00
Pittsfield	19,361.97	5,214.77	8,522.71	5,624.49	160	121.00
Greenfield	3,746.39	2,866.41	633.65	246.33	310	12.00
Total	$34,433.36	$17,707.18	$10,406.36	$ 6,319.82	683	$ 50.00
Vermont:						
Newport	$10,150.00	$ 2,000.00	$ 7,226.96	$ 923.04	181	$ 56.00
Winooski	10,000.00	4,736.10	1,000.00	4,263.90	242	41.00
Total	$20,150.00	$ 6,736.10	$ 8,226.96	$ 5,186.94	423	$ 48.00
Connecticut:						
Danielson	$25,632.21	$ 7,139.31	$ 9,148.80	$ 9,344.10	158	$162.00
Jewett City	13,886.00	1,015.00	8,609.00	4,262.00	268	52.00
Total	$39,518.21	$ 8,154.31	$17,757.80	$13,606.10	426	$ 93.00
Regional Totals	$94,101.57	$32,597.59	$36,391.12	$25,112.86	1,532	$ 61.00
REGION II						
New York:						
Watertown	$ 9,237.39	$ 2,319.19	$ 866.63	$ 6,051.57	216	$ 43.00
New Jersey:						
Orange	$ 5,278.31	$ -0-	$ -0-	$ 5,278.31	302	$ 18.00
Regional Totals	$14,515.70	$ 2,319.19	$ 8,666.63	$11,329.88	518	$ 28.00
REGION III						
Maryland:						
Salisbury	$10,775.00	$ 2,871.00	$ 3,155.75	$ 4,748.25	357	$ 30.00
Virginia:						
Roanoke	5,567.20	5,567.20	-0-	-0-	558	$ 10.00
Total	$ 5,567.20	$ 5,567.20	$ -0-	$ -0-		
Regional Totals	$16,342.20	$ 8,438.20	$ 3,155.75	$ 4,748.25	915	$ 18.00

HEAD START/EPSDT EXPENDITURES RE: DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS; COST PER CHILD

Table XIX (Cont'd)

	Total All Costs	Direct	Supportive	Admin.	No. Of Children Served	Cost Per Child
REGION IV						
Mississippi:						
Starkeville	$12,040.00	$ 5,228.00	$ 3,890.00	$ 2,922.00	413	$ 29.00
Yazoo	21,520.00	18,427.00	3,093.00	-0--	447	48.00
Total	$33,560.00	$23,655.00	$ 6,983.00	$ 2,922.00	860	$ 39.00
Tennessee:						
Kingston	$ 8,062.46	$ 4.149.17	$ 2,333.67	$ 1,579.62	226	$ 36.00
Alabama:						
Carrollton	$ 7,975.70	$ 7,109.70	$ 866.00	$ -0-	257	$ 31.00
Georgia:						
Monticello	$13,239.01	$11,580.01	$ 1,439.00	$ 220.00	68	$195.00
Gainesville	13,300.00	2,772.00	5,977.00	4,551.00	900	15.00
Total	$26,539.01	$14,352.01	$ 7,416.00	$ 4,771.00	968	$ 27.00
Kentucky:						
Frankfort	$20,000.00	$17,563.00	$ 1,252.00	$ 1,185.00	1,530	$ 13.00
Regional Totals	$96,137.17	$66,828.88	$18,850.67	$10,457.62	3,841	$ 25.00
REGION V						
Illinois:						
Cook County	$61,419.00	$45,812.00	$ 8,342.00	$ 7,265.00	652	$ 94.00
Waukegan	23,946.00	7,617.00	9,298.00	7,031.00	226	106.00
Total	$85,365.00	$53,429.00	$17,640.00	$14,296.00	878	$ 97.00
Wisconsin:						
Madison	$ 5,000.00	$ 1,180.00	$ 3,700.00	$ 120.00	508	$ 10.00
Superior,	5,503.00	-0-	-0-	5,503.00	557	10.00
Total	$10,503.00	$ 1,180.00	$ 3,700.00	$ 5,623.00	1,065	$ 10.00
Regional Totals	$95,868.00	$54,609.00	$21,340.00	$19,919.00	1,943	$ 49.0

HEAD START/EPSDT EXPENDITURES RE: DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS; COST PER CHILD

Table XIX (Cont'd)

	Total All Costs	Direct	Supportive	Admin.	No. of Children Served	Cost Per Child
REGION VI						
Texas:						
Witchita Falls	$ 7,946.57	$ 4,436.92	$ 994.46	$ 2,515.19	208	$ 38.00
San Antonio	5,904.05	5,000.00	797.55	106.50	732	6.00
Amarillo	9,553.00	5,000.00	2,108.00	2,445.00	732	13.00
Total	$23,403.62	$14,436.92	$ 3,900.01	$ 5,066.69	1,672	$ 14.00
Arkansas:						
Hot Springs	$24,978.84	$ 8,252.16	$ 115.00	$16,611.68	136	$184.00
Louisiana:						
Alexandria	$14,387.00	$10,586.00	$ 550.00	$ 3,251.00	741	$ 19.00
New Mexico:						
Carlsbad	$ 8,503.71	$ 5,000.56	$ 2,208.15	$ 1,295.00	189	$ 45.00
Oklahoma:						
Watonga	$37,242.00	$ 5,000.00	$ 8,050.00	$24,192.00	141	$264.00
Regional Totals	$108,515.17	$43,275.64	$14,823.16	$50,416.37	2,879	$ 38.00
REGION VII						
Missouri:						
Joplin	$ 6,175.00	$ 2,013.97	$ 4,157.13	$ 3.90	128	$ 48.00
Kirkville	5,627.00	627.00	3,146.00	1,854.00	137	41.00
Appleton	5,000.00	12.00	4,777.79	210.21	181	28.00
Total	$ 16,802.00	$ 2,652.97	$12,080.92	$ 2,068.11	446	$ 38.00
Kansas:						
Horton	$ 5,148.35	$ 40.00	$ 4,374.32	$ 734.03	269	$ 19.00
Girard	48,221.00	22,662.00	23,154.00	2,405.00	599	81.00
Total	$ 53,369.35	$22,702.00	$27,528.32	$ 3,139.03	868	$ 61.00
Regional Totals	$ 70,171.35	$25,354.97	$39,609.24	$ 5,207.14	1,314	$ 53.00

HEAD START/EPSDT EXPENDITURES RE: DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS; COST PER CHILD

Table XIX (Cont'd)

	Total All Costs	Direct	Supportive	Admin.	No. Of Children Served	Cost Per Child
REGION VIII						
Colorado:						
La Junta	$ 10,631.00	$ 10,488.00	$ 143.00	$ -0-	205	$ 52.00
Pueblo	14,855.00	10,000.00	3,900.00	955.00	357	42.00
Trinidad	11,602.00	5,960.60	4,032.00	1,609.40	145	80.00
Total	$ 37,088.00	$ 26,448.60	$ 8,075.00	$ 2,564.40	707	$ 52.00
Regional Totals	$ 37,088.00	$ 26,448.60	$ 8,075.00	$ 2,564.40	707	$ 52.00
REGION IX						
Hawaii:						
Kauai	$ 16,995.00	$ 6,626.00	$ 8,502.00	$ 1,867.00	158	$108.00
Regional Totals	$ 16,995.00	$ 6,626.00	$ 8,502.00	$ 1,867.00	158	$108.00
REGION X						
Oregon:						
La Grande	$ 11,938.94	$ -0-	$ 161.25	$11,777.69	49	$244.00
Eugene	46,629.65	15,782.65	11,601.00	19,246.00	222	210.00
Salem	15,599.00	5,500.00	9,175.00	924.00	326	48.00
Clatskanie	15,361.00	12,176.00	3,185.00	-0-	151	102.00
Total	$ 89,528.59	$ 33,458.65	$24,122.25	$31,947.69	748	$120.00
Regional Totals	$ 89,528.59	$ 33,458.65	$24,122.25	$31,947.69	748	$120.00
IMPD PROGRAMS						
Minnesota:						
White Earth	$ 44.65	$ -0-	$ 44.65	$ -0-	50	-
Montana:						
Flat Head	11,152.00	10,734.00	418.00	-0-	45	$248.00
Nebraska:						
Niobraro	$ 5,924.00	$ 5,708.00	$ 216.00	$ -0-	35	$162.0
Total IMPD	17,120.65	16,442.00	678.65	-0-	[illegible]	$132.00
GRAND TOTAL	$656,383.49	$316,398.72	$176,414.47	$163,520.21	14,685	$ 45.00

services; and to other areas directly ascribable to health services rendered to EPSDT participants. This finding supports a previous statement relative to the project staff administering direct health services and thereby, contributing to the low percentage in the use of Medicaid/EPSDT dollars.

Further analysis shows that a considerable share of monies spent was for supportive and administrative activiites--$176,414 and $163,570 respectively. Thus, 27 cents (27%) of every dollar was spent on supportive activities and 25 cents (25%) of every dollar went toward administrative functions.

It seems that adequate monies were generally provided by the project toward the objective of having Head Start assist the EPSDT program in delivering health-related supportive services to Medicaid eligible children in the community. Administrative costs, however, seem to be disproportionately high when considering the major objective of the program: to reach and provide EPSDT services to as many Medicaid eligible children as possible. This may be the result of requisite start-up activities for the program, e.g., staff orientation to EPSDT, meetings between Head Start staff and local Medicaid/EPSDT agencies, familiarization with and completion of data survey instruments, etc. by comparison, there were, of course, difference among regions and IMPD programs regarding the distribution of direct, supportive, and administrative costs and its proximity to the aggregate distribution of the universe (reference Exhibit VIII). For example, Region II reported that an inordinate amount of monies, approximately 75 cents of every dollar, was spent on administrative tasks, leaving very few monies for other services. Conversely, the IMPD projects indicated that nothing was expended for administrative activities. Rather, 96% of all expenditures were for direct services, with the remaining 4% going to supportive services. In this instance, it must be assumed that there is some error in reporting, since it is highly improbable that such a low percentage of administrative expenses would have been incurred.

A high incidence of direct services expenditures was also prevalent among Regions IV, V, and VIII-70%, 75% and 71%. Region I reported a low of 16% for direct services. The remaining regions averaged around 40%.

EXHIBIT VIII

DISTRIBUTION OF HEAD START/EPSDT EXPENDITURES RE: DIRECT, SUPPORTIVE, AND ADMINISTRATIVE COSTS

Region	Total Expend.-H.S.EPSDT	Direct	Supportive	Administrative
I % Distribution	94,101 100%	32,597 35%	36,391 39%	25,113 26%
II % Distribution	14,515 100%	2,318 16%	867 6%	11,330 79%
III % Distribution	16,342 100%	8,438 52%	3,156 19%	4,748 28%
IV % Distribution	96,138 100%	66,830 70%	18,851 20%	10,457 10%
V % Distribution	95,868 100%	54,609 57%	21,340 22%	19,919 21%
VI % Distribution	108,516 100%	43,277 40%	14,823 14%	50,416 46%
VII % Distribution	70,171 100%	25,355 36%	39,609 56%	5,207 8%
VIII % Distribution	37,088 100%	26,449 71%	8,075 22%	2,564 7%
IX % Distribution	16,995 100%	6,626 39%	8,502 50%	1,867 11%
X % Distribution	89,529 100%	33,459 37%	24,122 27%	31,948 36%
IMPD % Distribution	17,121 100%	16,442 96%	679 4%	- -
Aggregate Total % Distribution	656,384 100%	316,400 48%	176,415 27%	163,569 25%

NOTE: Information is based on a total of 45 projects reporting.

In the supportive cost category, Region VII was highest, with expenditures amounting to 56% of the total. Region IX and I then follow with 50% and 39% respectively. With the exception of IMPD programs, Region II was lowest in support service expenditure with only a 6% allocation and Region VII was moderately low at 14%. Other regions expended 20% or more for supportive service activities.

Administrative expenditures outside of Region II ranged from 7% to 46%. Region VI reported 46% while Regions VII, IV, and IX indicated considerably lower percentages at 8%, 10%, and 11%. An average of 28 cents for every dollar was spent by the remaining regions, I, III, V and X, on administrative duties.

The average annual per child cost among all regions and IMPD programs was reported at $45.00. This figure appears to be extremely low since the national annual per child cost of health services to AFDC Medicaid recipients was assessed at $165 per child* Again, one can speculate that the low average may be attributable to under reporting by the demonstration projects of monies used to support the collaborative effort. This, of course, bears directly on the per child cost of health and related services.

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*This figure was taken from Health Start: Final Report of the Evaluation of the Second Year Program, December 1973. pg. VII-14. The calculation was based on information from "National Health Expenditure, 1969-1971, "Social Security Bulletin, January 1972.

Reporting among projects regarding per patient cost varied considerably. Data from Table XIX shows that per child cost of health and related services for Head Start/EPSDT ranged from eight dollars to $264.00 among the various projects. These amounts were reported by Opportunities Development Corporation of San Antonio, Texas and Opportunities, Inc. of Watonga, Oklahoma, respectively. Both these projects are Region VI affiliates.

The IMPD programs indicated the highest per child cost at $132.00. Regions X and IX followed, reporting $120.00 and $108.00, respectively. The lowest per child cost was reported by Region III - $18.00

Data from Table XIX also shows that considerably low per child costs were reported by Regions IV and II - $25.00 and $28.00 The remaining regions (I, VI, VII, and VIII) reported amounts closer to the overall average per child cost.

3. Conclusions

a. Expenditures for Head Start/EPSDT varied from project to project; about 75% of the total EPSDT expenditures for all regions and IMPD programs originated from the Head Start/EPSDT supplemental grant. Contributions from other sources were minimal

b. Medicaid/EPSDT only accounted for 6% of all EPSDT expenditures. It appears that many projects are providing requisite EPSDT screening services to collaboration participants themselves. Lack of providers, failure to reimburse for certain services in accordance with the EPSDT state plan. et al. may be contributing factors to the low percentage of Medicaid/EPSDT expenditures.

c. Analysis of the data indicated that programs extended beyond the supplemental grant to support the collaborative effort, which suggests that the supplemental grant alone was not sufficient to sustain the implementation of Head Start/EPSDT.

d. Overall, 48% of all dollars expended by the demonstration projects for the EPSDT program was for direct health services, with 27% and 25% attributable to supportive costs and administrative costs, respectively.

e. Projects allocated adequate monies for supportive services to satisfy the objective of soliciting as many Medicaid eligible children as possible for participation in the program. But it appears that more discretion could have been exercised regarding the relatively high cost of administrative services, in view of the overall objective of reaching and serving as many children as possible.

f. Per child costs fluctuated considerably among the projects. The average per child cost, however, was assessed at $45.00.

4. Policy Considerations

a. The demonstration projects could begin to take a serious look at where they are spending money relative to fullfilling the objectives of Head Start/EPSDT. Certainly if one of the primary objectives of the program is to reach and provide supportive services to Medicaid eligible children, then programs must identify, within the total program concept, the monies needed to accomplish this objective. Thus, it is likely that more should be spent in this area. Expenditures in other areas of less priority could, by contrast, be held to a minimum.

b. Programs could begin to become more cost conscious. They could consider alternative ways of monitoring EPSDT expenditures other than by line-items expenditure, particularly in light of emphasis (in the second year program) on projects qualifying as vendors for third-party reimbursements. In negotiating EPSDT purchase of service agreements, many state and/or local Medicaid agencies require that costs be stratified by direct and administrative services. In some instances, a determination of supportive costs is requested. This is done for purposes of the state ascertaining the services for which they will reimburse. A consideration, therefore, is that projects would adopt a system which begins to meet this need. Such a system not only provides a means for identifying costs for reimbursement requirements, but can also be useful as a management tool for budgeting and planning purposes. Moreover, it provides management with the requisite information as to dollar spending relative to program objectives and further establishes the parameters necessary for any decision-making as to the most cost-effective approach for reaching these objectives.

c. In light of the uncertainty of future collaborative effort funding, stronger emphasis will be placed on programs to take full advantage, wherever possible, of all Medicaid/EPSDT reimbursable services. Programs could also be encouraged to make every attempt to secure vendor recognition.

d. Because of the unreliability of cost/revenue data, more emphasis could be placed on the retrieval of this information in the proposed second year evaluation, particularly in light of the programs poor response rate and apparent misunderstanding of what was requested. A closer look at the impact of EPSDT Medicaid dollars on the collaborative effort might be a key consideration.

C. MEDICAID INVOLVEMENT IN THE PAYMENT OF EPSDT SERVICES TO MEDICAID CERTIFIED PARTICIPANTS

Data from table XX presents information concerning Medicaid's involvement in the payment for EPSDT services received by Medicaid certified participants. Information is arrayed by the particular health service category for Head Start and non-Head Start enrollees. Reporting is based on information obtained from the Health Care Encounter Form relative to the 24 selected projects. No attempt was made, here, to assess the dollar value of Medicaid payments, as this information could not be retrieved from the aforementioned form. Rather, the data focuses on the units of health services received by Medicaid certified participants in which Medicaid was involved as a payment source. This finding is then expressed as a percentage to the whole of units of health services received which were paid for by Medicaid, in whole or part.

1. Analysis of Findings

Data indicated that 51% of all health services received by the Medicaid certified population--both Head Start and non-Head Start participants--among the selected projects was paid for, in whole or part, by Medicaid. Surprisingly, non-Head Start children had a greater percentage (63%) of their health services paid for by Medicaid than did Head Start children (50%).

MEDICAID INVOLVEMENT IN THE PAYMENT OF UNITS OF EPSDT SERVICES FOR MEDICAID CERTIFIED PARTICIPANTS BY HEALTH SERVICE

Table XX

Health Service	Total Units of Services Received By Med. Certified Children	Units of Services Received by Med. Cert. Children		Units of Service Paid for by Medicaid				% of Services Received Paid for by Medicaid		Average % for HS & NH
				HS		NHS				
		HS	NHS	Yes	No	Yes	No	HS	NHS	
Medical	3,900	3,424	476	2,853	571	457	19	83%	96%	85%
Dental	3,298	2,970	328	2,198	772	319	9	74%	97%	76%
Mental Health	1,428	1,406	22	206	1,200	5	17	14%	23%	15%
Nutritional	3,430	3,001	429	117	2,884	7	422	4%	2%	4%
Total	12,056	10,801	1,255	5,374	5,427	788	467	50%	63%	51%

NOTE: Figures do not represent numbers of Medicaid children receiving health services. Rather, they represent the units of health services received (within each category) by Medicaid certified participants.

This followed throughout each of the major categories of health service, with the exception of nutritional services. It is speculated that this trend was a result of less contact by the programs with the non-Head Start certified children regarding the full range of EPSDT mandated services and/or the probability of needed follow-up treatment. Medicaid in many instances does not reimburse for the full range of health services. Because Head Start Medicaid children are more likely to be the recipients of total health services as opposed to non-Head Start Medicaid certified children, the greater the possibility becomes for Medicaid not to be involved in the payment process.

Data also indicates that Medicaid was most responsive in participating in the payment for medical and dental services administered to Medicaid certified children. Medicaid's involvement as a payment source in these areas was reported at 85% and 76%, respectively. On the other hand, Medicaid's involvement in the payment for mental and nutritional health services was considerably low at 15% and 4%.

2. Conclusions

a. While the effectiveness of EPSDT Medicaid in terms of its dollar contribution to the collaborative effort cannot be assessed, it is concluded that the Head Start projects were reasonably effective in involving Medicaid in the payment of reimbursable services in accordance with their respective EPSDT State Plans.

b. EPSDT Medicaid as a viable source for the payment of Medical and Dental services appears adequate, but falls considerably short for the payment of mental health and nutritional services.

3. Policy Considerations

a. Head Start projects could be encouraged, wherever possible, to maximize their efforts to involve Medicaid in the payment of EPSDT services, particularly where such services are reimbursable according to the EPSDT State Plan

b. Projects could also be encouraged to negotiate with state/local Medicaid agencies for reimbursement rates which more reasonably reflect the actual costs or the going community rate for providing EPSDT services. This could possibly increase the number of Medical providers willing to participate in the EPSDT effort who were reluctant to do so before because of low remuneration (from Medicaid) for services rendered.

c. Projects could be encouraged to negotiate with state/local Medicaid agencies for reimbursement for the full range of EPSDT services provided. e.g. supportive services such as transportation. This would reduce the cost to Head Start for the implementation and maintenance of the collaborative effort and allow these dollars to be reprogrammed for other priority considerations relative to the collaboration.

D. ASSESSED VALUE OF HEAD START/EPSDT HEALTH SERVICES FOR SELECTED PROJECTS

Information obtained applicable to the assessed value of services regarding medical, dental, mental health, nutritional services, etc., proved to be unreliable. Most projects experienced difficulty in providing this information. There was apparent confusion among the demonstration projects as to the exact meaning of assessed value of services.

To highlight this confusion in this area, one project reported the assessed value of all services received at over $4,000,000. This was more than the total amount reported by all other selected projects combined. Other projects also reported unreasonable amounts.

Information germane to this area was obtained from the Health Care Encounter Form for the selected projects. The assessed value of services was to be reported as the cost that would normally be incurred by Head Start for the provision of EPSDT health services to Medicaid certified children. This amount, which would presumably exceed the total amount of monies paid by Medicaid for reimbursable EPSDT services, would constitute the additional dollars needed from Medicaid to support the collaborative effort.

Conclusions

With the apparent confusion/difficulty most of the selected projects had in gathering information on the assessed value of Head Start/EPSDT services, there were no discernible conclusions reached on this aspect of the study.

Policy Considerations

a. Because of the apparent confusion caused by the use of such terminology as "assessed value of services", it is suggested that this phrase be dropped for purposes of the proposed second year evaluation. Rather, it seems only necessary to request the demonstration projects to report the amount of monies they spend, beyond those reimbursed by Medicaid, on EPSDT services rendered to Medicaid certified participants. This will serve to indicate the total amount of monies needed from Medicaid to fully support the collaborative effort relative to the Medicaid certified population.

b. While most projects do not maintain their accounting records in this manner, it should not be difficult to collect this information. An accounting of the services received by the Medicaid certified children and the related reimbursement reates allowed by Medicaid for same would form the basis for calculation. This information could be retrieved from each of the demonstration projects via the proposed revised End-of-Year-Status Form.

c. Where site visits are made, a more intensive look at the recordkeeping systems and the respective reimbursement plans could be conducted to retrieve this information.

APPENDIX A

APPENDIX A

PROFILE OF IMPD PROJECTS

Three IMPD programs were included among the selected Head Start/EPSDT projects. Two of the projects, Blackfeet Tribe Business Council and Fort Peck, were located on Indian reservations in Montana; the other project, the Greater California Education Project in Fresno, California, served children of migrant workers.

The Indian and migrant projects differed along the following dimensions:

- Sponsorship:
  - Indian projects: the Office of Native American Programs (ONAP) Councils of the particular reservations on which they were located.
  - Migrant projects: indepedent umbrella organizations directed to migrant workers; the sponsor organization's primary function was manpower training programs.
- Funding:
  - The Indian projects received minimal supplemental grants for the Collaborative Effort which were applied to the health coordinators' salary. Administrative and some operational expenses, e.g., for transportation and non-reimbursed health services not provided by the Indian Health Services (IHS), were paid for through the regular Head Start budget* and supplemental monies provided by the ONAP council.

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*Indian programs do not receive any health services funding because the Indian Health Service is expected to provide necessary care.

- The migrant project also received a relatively small supplemental grant. Funds were available from the project's health services program and the sponsoring organization.

. Support From Other Health Programs:

- Both Indian projects relied on IHS and the migrant project had access to special health programs provided for the migrant workers. The Blackfeet Tribe received extensive support from IHS which brought in special resources to the reservation for testing. Arrangements were also made for additional consultation with an off-reservation service resource. In this case IHS personnel generally had a sympathetic attitude toward EPSDT and were supportive of Head Start.

  The Fort Peck Indian project did not fare as well. In this case, concerned IHS personnel appeared to view EPSDT as redundant and somewhat of an intrusion; in addition, some strain was apparent between the service and Head Start, possibly stemming from the project's attempts to press IHS for more services, particularly follow-up. In both cases, some of the IHS procedures with respect to authorizations for and scheduling of treatment posed some, although not insurmountable, problems.

- The Fresno migrant project made extensive use of special migrant health resources for both medical and dental screening and treatment. Use of the migrant health resources had both advantages and disadvantages. Although many children received care probably not otherwise obtainable, it tended to be sporadic and episodic. Frequent moves of the families were a contributing factor, as were the locations, hours of service and administrative practices of the projects.

APPENDIX B

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SUMMARY OF FORMS

- Health Care Intake Form: a form to be used by each funded project and completed once for each child participating in the Head Start EPSDT Collaborative Effort, at the time he is first recruited for EPSDT services. It is designed to collect information regarding:

  - the child's Medicaid status
  - the child's status with regard to Head Start
  - the child's previous health record for the twelve months prior to the collaborative effort.

- Health Care Encounter Form: to be completed monthly for each child in the 30 selected projects only. It is designed to collect data cumulatively by child on the following elements of health care service provided:

  - the type of visit (screening, diagnostic, counseling/referral, or treatment)
  - the disposition of the case (including follow-up visits where indicated)
  - the assessed value of the provided services.

- Health Care Composite Visit Form: to be completed monthly by project for the remaining 170 projects. It records information separately for Head Start and non-Head Start children regarding:

  - the total number of visits by type (screening, diagnostic, counseling/referral, or treatment) of children in the project during that month
  - the disposition of cases (the number of referrals, follow-ups, and completed cases).

- End of the Year Status Report: designed to be completed cumulatively by project at the end of the year. Collects information regarding:

  - the participating children's Medicaid status
  - the amount of turnover the project experienced
  - the disposition of medical records.

- Staff Profile Form: designed to record information regarding staffing patterns for the Head Start/EPSDT Collaboration Effort. Collects information regarding the staff's:
  - employment status
  - duties and responsibilities
  - educational background
  - previous employment/experiences.
- Time Utilization Form: designed to assess the quarterly distribution of the Head Start/EPSDT staff time to the following categories:
  - direct labor
  - supportive labor
  - administrative labor.
- Income Sources Form: designed to be completed once during the program year to identify the extent to which the Head Start program is making use of available resources.
- Expenditure Form: designed to be completed once a year to collect information on how available resources are used to fulfill the requirements of the Head Start/EPSDT Collaboration Effort.
- Medicaid Profile Form: designed to be completed by the Health Liaison Specialist. Collects background information on the Head Start project regarding its status and its understanding of EPSDT Medicaid.